C. Subpart C -- State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

1. Basis, scope, and applicability (§457.300).

This subpart interprets and implements provisions of section 2102 of the Act which relate to eligibility standards and methodologies and to coordination with other public health insurance programs; section 2105(c)(6)(B), which precludes payment for expenditures for child health assistance provided to children eligible for coverage under other Federal health care programs other than programs operated or financed by the Indian Health Service; and section 2110(b), which defines the term "targeted low-income child." This subpart sets forth the requirements relating to eligibility standards and to screening, application and enrollment procedures. We proposed that the requirements of this subpart apply to a separate child health program and, with respect to the definition of targeted low-income child only, to a Medicaid expansion program.

As discussed in the response to the first comment below, we have removed from the proposed definition of "optional targeted low income child" for purposes of a Medicaid expansion the cross reference to §457.310(a) in subpart C and have revised the definition of "optional targeted low-income child", which is now located at §§435.4 and 436.3 of this chapter. Comments regarding optional targeted low-income children for purposes of a Medicaid

expansion program are addressed in the preamble to subpart M. Conforming changes have been made to the definition of "targeted low-income child" at §457.310. This subpart now applies only to a separate child health program.

We received no comments on §457.300 and, with the exception of the one change noted, are implementing it as proposed. General comments on subpart C are discussed in detail below.

Comment: We received two requests that the Medicaid regulations clarify the definition of "optional targeted low-income child." The commenters are of the opinion that the cross-reference to the title XXI regulations is confusing. They note that some provisions in title XXI, such as permitting States to limit eligibility by geographic region, do not apply in Medicaid.

Response: We accept the commenters' request to clarify the definition of optional targeted low-income child in the Medicaid regulations, rather than cross-reference §457.310(a). In proposed §435.229(a), the cross-reference to §457.310(a) incorporated provisions of the definition of targeted low-income child that only apply in a separate child health program. We have removed the cross-reference to §457.310(a) and added a specific Medicaid definition of optional targeted low-income child in §435.4 (and in § 436.3 for Guam, Puerto Rico, and the Virgin Islands).

Comment: We received a number of comments recognizing that

certain policies were statutory and urging HCFA to seek statutory changes. The suggested changes included the following:

Allow a State the option to keep a pregnant teen enrolled in a separate child health program even if she becomes eligible for Medicaid as a pregnant woman.

Allow States to deem an infant eligible for a separate child health program for a full year if the birth is covered by a separate child health program.

Response: We will take these suggestions into consideration in developing future legislative proposals and appreciate the commenters' recognition that these issues are driven by the statute.

Comment: Several commenters were concerned about the interaction of various public programs. Two urged HCFA to reiterate the importance of ensuring the Medicaid eligibility is not tied to eligibility for Temporary Assistance for Needy Families (TANF) under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).

Response: Under the welfare reform provisions of PRWORA, the link between Medicaid and cash assistance (previously given as Aid To Families with Dependent Children, or AFDC) was severed. This "delinking" of Medicaid from cash assistance assured Medicaid eligibility for low-income families regardless of whether the family is receiving welfare payments, and offers

States new opportunities to provide a broader range of low-income families health care coverage. In an effort to help States better understand their opportunities and responsibilities under the law, DHHS, HCFA, and the Administration on Children and Families (ACF) have issued substantial guidance on how to implement the delinking provisions, including fact sheets, letters to State Medicaid and TANF Directors, updates to the State Medicaid Manual, and the publication of a 28-page, plain-English guide entitled, *"Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World."* State Medicaid Director letters dated October 4, 1996, February 5, 1997, April 1, 1997, September 22, 1997, and August 17, 1998 dealt with the implementation of the section 1931 eligibility category; letters dated February 6, 1997 and April 22, 1997 discussed redetermination procedures; and eight additional letters covered immigration, outreach and enrollment, MEQC errors, and the availability of the $500 million delinkage fund. Last fall, at the direction of President Clinton, HCFA conducted comprehensive on-site visits in all States to review State TANF and Medicaid application and enrollment policies and procedures. HCFA is currently finishing the ensuing reports and working with the States to address problems that have been identified. An April 7, 2000 letter to State Medicaid Directors requires States to take steps to identify and reinstate

individuals who have been terminated improperly from Medicaid and to ensure that their computer systems are not improperly denying or terminating persons from Medicaid. The letter also provides important guidance regarding redetermination. A series of Questions and Answers concerning this letter can be found under the heading “Welfare Reform and Medicaid” on HCFA’s web site at: http://www.hcfa.gov/medicaid/medicaid.htm.

Based on the findings of HCFA’s reviews and the reviews that States are undertaking to comply with the April 7, 2000 guidance, HCFA is providing further guidance and technical assistance to States in the areas of application and notice simplification, outreach to eligible families, and modification of computer systems, among others. HCFA, in partnership with ACF, the Food and Nutrition Service, the American Public Human Services Association, and the National Governors Association, is also disseminating best practices so that States can assist one another as they move forward to correct problems and improve participation among eligible low-income families.

Comment: We received one comment urging HCFA to include information about presumptive eligibility under a separate child health program in the preamble to the SCHIP financial regulation. Another urged HCFA to encourage States to provide presumptive eligibility for children as this is particularly important to children experiencing a mental health crisis.

Response: States have the authority to implement a presumptive eligibility procedure under its separate child health program. This was implicit under title XXI as originally enacted and now, with the enactment of the Benefits Improvement and Protection Act of 2000(BIPA) (Pub.L. 106-554), the authority to implement presumptive eligibility procedures in separate child health programs is explicit.

Under section 803 of BIPA, States have the option to establish a presumptive eligibility procedure and, consistent with the flexibility now granted States under the Medicaid presumptive eligibility option (see section 708 of BIPA, amending section 1920A(b)(3)(A)(i) of title XIX), States have broad discretion to determine which entities shall determine presumptive eligibility, subject to the approval of the Secretary. For example, States can rely on health care providers, child care providers, WIC, or Head Start centers, or the contractors that may be doing the initial SCHIP/Medicaid eligibility screen.

Under the presumptive eligibility established under Medicaid and carried over to SCHIP under the BIPA legislation, a family has until the end of the month following the month in which the presumptive eligibility determination is made to submit an application for the separate child health program (or the presumptive eligibility application may serve as the application

for the separate child health program, at State option). If an application is filed, the presumptive eligibility period continues until the State makes a determination of eligibility under the separate child health program (subject to the Medicaid screening requirements). In accordance with section 457.355, if a child enrolled in a separate child health program on a presumptive basis is later determined to have been eligible for the separate child health program, the costs for that child during the presumptive eligibility period will be considered expenditures for child health assistance for targeted low-income children and subject to the enhanced FMAP. If the child is found to have been Medicaid-eligible during the period of presumptive eligibility, the costs for the child during the presumptive eligibility period can be considered Medicaid program expenditures, subject to the appropriate Medicaid FMAP (the enhanced match rate or the regular match rate, depending on whether the child is a optional targeted low-income child).

We have revised the policy stated in the preamble of the proposed rule regarding children who are enrolled through presumptive eligibility, but who are later not found to be eligible under the separate child health program or Medicaid. In the proposed rule, we noted that the costs for coverage of such children during the presumptive period must be claimed as SCHIP administrative expenditures, subject to the enhanced match and

the 10 percent cap. BIPA, however, authorizes presumptive eligibility under separate child health programs in accordance with section 1920A of the Act, and the statute now allows health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

Comment: One commenter thought that greater coordination among HCFA, the Office of Child Support Enforcement (OCSE), State child support agencies, and SCHIP stakeholders would increase the likelihood of children receiving the best available health care. The commenter noted that many children who qualify for SCHIP are members of single-parent families and could benefit from the services of the child support program. Conversely, SCHIP programs can ensure that children have access to quality health care when a noncustodial parent’s employer does not offer health insurance, the health insurance is available only at a prohibitive cost, or it is not reasonably accessible to the

child. Another commenter suggested that the preamble explicitly note the prohibition on denying Medicaid to children on the grounds that their parents have failed to cooperate with establishing paternity or with medical support enforcement and also highlight that States do not need to include questions about noncustodial parents on their joint applications, but rather can solicit such information at the time that they notify the family of eligibility.

Response: We agree that it is important that children benefit from the services of the child support program. HCFA has issued guidance to States under title XIX about the importance of informing families who receive Medicaid about available State Child Support Enforcement services. We have instructed State Medicaid agencies to coordinate with State CSE agencies to ensure that children who could benefit from these services receive them. We encourage States to inform families who apply for coverage under their separate child health programs about CSE services.

CSE agencies can also serve as a source of information about available health care coverage for families who seek CSE services. In many cases, families are not able to secure health care coverage through a child's absent parent. In such cases, CSE can help the family obtain coverage through SCHIP or Medicaid if the State promotes coordination between its CSE and child health coverage. Several States have reported taking such steps

as part of their outreach and coordination activities.

While child support services can provide important support to many families, questions about absent parents on a child health application can be a barrier to enrollment. Under Medicaid, the recent guidance issued to State Medicaid agencies reiterates that cooperation of a parent with the establishment of paternity and pursuit of support cannot be made a condition of a child's eligibility for Medicaid. Moreover, the guidance informs States that they are not required to request information about an absent parent on a Medicaid application (or a joint Medicaid/separate child health program application) that is only for a child and not for the parent.

Comment: One commenter felt that the eligibility screens and information requirements in the proposed regulations went beyond the statutory requirements, are excessively burdensome and will make it impossible to effectively coordinate with other programs, such as the school lunch program, Head Start, or WIC.

Response: We disagree with the commenter's assertion that the regulations have created barriers to enrollment in the SCHIP program. We have provided States with considerable flexibility with respect to how to meet the requirements of the statute, and have worked in this final rule to further expand that flexibility in many cases. The statute specifically requires that States screen all applicant children for Medicaid eligibility and enroll

them in Medicaid if appropriate. To that end we have encouraged, and the majority of States have adopted, joint applications which significantly decrease the complexity of the application and enrollment process. We have permitted States flexibility with respect to the design of their applications and their application processes, although we encourage States to streamline the enrollment process in SCHIP and Medicaid (for example, elimination of assets tests, using mail-in applications, minimizing verification requirements) to enable families to access coverage under a separate child health program or Medicaid as quickly and easily as possible. We acknowledge the difficulties that exist in coordinating different public programs and have provided flexibility wherever possible; but that flexibility is constrained by the statutory provisions that are designed to ensure that children are enrolled in the appropriate program. States have taken advantage of the flexibility permitted to design varied and effective coordination procedures. We are committed to working closely with the States to help them implement procedures that work effectively for them and to share their ideas and experiences with other States.

2. Definitions and use of terms (§457.301).

This section includes the definitions and terms used in this subpart. Because of the unique Federal-State relationship that is the basis for this program and in keeping with our commitment

to State flexibility, we determined that many terms should be left to the States to define. For purposes of this subpart, we proposed to define the terms "employment with a public agency," "public agency," and "State health benefits plan."

We proposed to define "public agency" to include a State, county, city or other type of municipal agency, including a public school district, transportation district, irrigation district, or any other type of public entity. We proposed to define the term "employment with a public agency" as employment with an entity under a contract with a public agency. The term was intended to include both direct and indirect employment because we did not wish to influence or restrict the organizational flexibility of State and local governmental units. We proposed to define the term "State health benefits plan" as a plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State.

Comment: Commenters objected to the definition of "employment with a public agency" as being too inclusive. They noted particular concern about the inclusion of "entities contracting with a public agency" in the definition. Commenters felt the inclusion of this group could unfairly deny coverage to children in families who are not State employees.

Response: We are deleting our proposed definition of

"employment with a public agency" in §457.301. In §457.310(c)(1)(i), we will track the statutory language at section 2110 (b)(2)(B), which excludes from eligibility "a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State." State law will determine whether parents employed by contracting agencies are employed by a public agency and whether their children are eligible for health benefits coverage under a State health benefits plan. If the State determines that a child is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State, then the child is ineligible for coverage under a separate child health program. In addition, we have revised the definition of "State health benefits plan" to clarify that we would not consider a benefit plan with no State contribution toward the cost of coverage and in which no State employees participate as a State health benefits plan.

3. State plan provisions (§457.305).

In accordance with the requirements of section 2102(b)(1)(A) of the Act, we proposed to require that the State plan include a description of the State's eligibility standards.

Comment: Several organizations commented that HCFA should require States that limit the number of children who can enroll

in a separate child health program to describe their procedures for deciding which children will be given priority for enrollment and how States will ensure that equal access is provided to children with pre-existing conditions; their processes for discontinuing enrollment if program funds are depleted; how they will comply with the prohibition on enrolling children at higher income levels without covering children at lower income levels; how the waiting lists will be fairly administered. The commenters also suggested that we require these States to maintain sufficient records to document that favoritism or discrimination does not occur in selecting individuals for enrollment. Additionally, commenters suggested that §457.305 or §457.350, should specifically require that a Medicaid screen be conducted before a child is placed on a waiting list.

Response: States are required under §457.305 to include as part of their State plan a description of their standards for determining eligibility. We are clarifying in regulation text that this must include a description of the processes, if any, for instituting enrollment caps, establishing waiting lists, deciding which children will be given priority for enrollment. This clarification of the regulation text conforms with actual HCFA practice. HCFA has requested States that have adopted enrollment caps to describe in their State plans their policies for establishing enrollment caps and waiting lists and for

enrolling children from any waiting lists. We also have added a provision at §457.350(h) requiring that applicants must be screened for Medicaid prior to being placed on a waiting list due to an enrollment cap. Not doing so would place Medicaid-eligible children on a waiting list and undermine a fundamental goal of the statute -- to enroll children in health insurance programs for which they are eligible. In this case, arrangements must be made for the joint application to be processed promptly by the Medicaid program.

States must afford every individual the opportunity to apply for child health assistance without delay in accordance with §457.340, and facilitate Medicaid enrollment, if applicable, in accordance with §457.350, prior to placing a child on a waiting list for a separate child health program. We have amended the language of §457.305 (relating to State plan requirements) to reflect this requirement.

If, after a State plan is approved by HCFA, the State opts to restrict eligibility by discontinuing enrollment, by establishing an enrollment cap, or by instituting a waiting list, the State must submit a State plan amendment requesting approval for the eligibility changes as required by §457.60(a). Because we believe these changes in enrollment procedures constitute restrictions of eligibility, the amendment must be submitted in accordance with the requirements at §457.65(d). With respect to

public input, HCFA also requires in §457.120 that States ensure ongoing public involvement once the State plan has been submitted.

4. Targeted low-income child (§457.310).

In accordance with §2110(b) of the Act, we proposed to define a targeted low-income child as a child who meets the eligibility requirements established in the State plan pursuant to §457.320 as well as certain other statutory conditions specified in this section. At §457.310(b), we set forth proposed standards for targeted low-income children that relate to financial need and eligibility for other health coverage, including coverage under a State health benefits plan. In addition, we set forth exclusions from the category of targeted low-income children.

With regard to financial need, we proposed that a child who resides in a State with a Medicaid applicable income level, must have: (1) family income at or below 200 percent of the Federal poverty line; or (2) family income that either exceeds the Medicaid applicable income level (but by not more than 50 percentage points) or does not exceed the Medicaid applicable income level determined as of June 1, 1997. We left States the discretion to define “income” and “family” for purposes of determining financial need.

We note that we have modified §457.310(b)(1) to clarify the

definition of targeted low-income child. We made technical corrections, in accordance with section 2110(b) to indicate that a targeted low-income child may reside in a State that does not have a Medicaid applicable income level and that a targeted low-income child may have a family income at or below 200 percent of the Federal poverty line for a family of the size involved, whether or not the State has a Medicaid applicable income level. In addition, we have revised proposed §457.310(b)(1)(iii), now §457.310(b)(1)(iii)(B), for purposes of clarity. A targeted low-income child who resides in a State that has a Medicaid applicable income level, may have income that does not exceed the income level that has been specified under the policies of the State plan under title XIX on June 1, 1997. This provision effectively allows children who became eligible for Medicaid as a result of an expansion of Medicaid that was effective between March 31 and June 1, 1997 to be considered targeted low-income children. It also means that children who were below the Medicaid applicable income level but were not Medicaid eligible due to financial reasons that were not related to income (e.g. due to an assets test) can be covered by SCHIP.

With regard to other coverage, we proposed that a targeted low-income child must not be found eligible for Medicaid (determined either through the Medicaid application process or the screening process discussed later in this preamble); or

covered under a group health plan or under health insurance coverage, unless the health insurance coverage has been in operation since before July 1, 1997, and is administered by a State that receives no Federal funds for the program's operation. However, we proposed that we would not consider a child to be covered under a group health plan if the child did not have reasonable access to care under that plan.

With regard to exclusions, we proposed at §457.310(c)(1) that a targeted low-income child may not be a member of a family eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency so long as more than a nominal contribution to the cost of the health benefit plan is available from the State or public agency with respect to the child. We proposed to set the nominal contribution at $10.

Section 2110(b)(2)(A) of the Act excludes from the definition of targeted low-income child a child who is an inmate of a public institution or who is a patient in an institution for mental diseases (IMD). We proposed to use the Medicaid definition of IMD set forth at §435.1009, which provides, in relevant part, that an IMD "means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and

related services."

We proposed to apply the IMD eligibility exclusion any time an eligibility determination is made, including the time of application or any periodic review of eligibility (for example, at the end of an enrollment period). Therefore, a child who is an inpatient in an IMD at the time of application, or during any eligibility determination, would be ineligible for coverage under a separate child health program. If a child who is enrolled in a separate child health program subsequently requires inpatient services in an IMD, the IMD services would be covered to the extent that the separate program includes coverage for such services. However, eligibility would end at the time of redetermination if the child resides in an IMD at that time. We stated that we were reviewing the IMD policy and considering various options. We solicited comments on an appropriate way to address this issue.

We proposed to use the Medicaid definition of "inmate of a public institution" set forth at §435.1009. Accordingly, we stated in the preamble to the proposed regulation that when determining eligibility for a separate child health program, an individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. We also stated in the preamble to the proposed regulation that a facility is a

public institution if it is run, or administratively controlled by, a governmental agency.

Under Medicaid, FFP is not available for medical care provided to inmates of public institutions, except when the inmate is a patient in a medical institution. We proposed to allow this same exception for a separate child health program because we believe an inmate residing in a penal institution who is subsequently discharged or temporarily transferred to a medical institution for treatment is no longer an "inmate." Therefore, an inmate who becomes an inpatient in a medical institution that is not part of the penal system (that is, is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility that is not part of the penal system), would be eligible for a separate child health program (subject to meeting other eligibility requirements), and the State would receive FFP for medical care provided to that child. If the child is taken out of the medical institution and returned to a penal institution, the child again would be excluded from eligibility for the separate child health program.

Comment: Numerous commenters supported the proposed policy that a child would not be considered covered under a group health plan if the child did not have reasonable access to care under that plan and several others requested further clarification. A

third group of commenters also recommended that States should be allowed to determine when a plan is inaccessible.

Response: The intention of the "reasonable access to care" standard is to provide relief for children who are covered by a health maintenance organization or managed care entity not in close geographic proximity through the employer of a non-custodial parent and cannot get treatment in the locality in which they reside due to service area or other restrictions. HCFA recognizes that it is often difficult for such children to be removed from coverage under their non-custodial parent's health plan, because it is often court-mandated coverage and the custodial parent may not be able to terminate such coverage. We therefore defined these children as lacking "reasonable access to care." While we recognize that health coverage that is unaffordable due to high premiums or deductibles also presents issues of access, the statute precludes children who are covered under a group health plan or under health insurance coverage (as defined under HIPAA and reflected in our definitions) from receiving coverage under a separate child health program. We note that some States have established eligibility for children whose families have dropped such unaffordable coverage and it is within their discretion to adopt such procedures. However, we believe that to permit children who are currently enrolled in a group health plan or other health insurance coverage, other than

children who do not have reasonable geographic access to coverage, to enroll in a separate child health program would contradict the statute. We have revised §457.310(b)(2)(ii) to clarify that a child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan.

Comment: Several commenters requested additional guidance on whether children covered under a plan which provides limited benefits only, such as policies covering only school sports injuries, vision, dental, or catastrophic care, or those with high deductibles, have access to insurance. One commenter requested that HCFA allow States to consider a child's access to dental services when making eligibility determinations. Clarification also was requested on whether school health insurance is considered creditable coverage.

Response: Section 2110(b)(1)(C) of the Act excludes from the definition of targeted low-income children a child who is "covered under a group health plan or under health insurance coverage" as those terms are defined in §102 of the Health Insurance Portability and Accountability Act (HIPAA), which added section 2791 to the Public Health Service Act (PHSA), 42 U.S.C. 300gg-91(c). HIPAA and the implementing regulations (found at 45 CFR 146.145 and 148.220), in turn, exempt certain "excepted benefits" from some of the requirements of HIPAA to which group

health plans and group health insurance are otherwise subject. Consistent with this treatment under HIPAA, a group health plan or group health insurance which meets the definition of “excepted benefits” also will not be considered as a group health plan or health insurance coverage for eligibility purposes. Under section 2110(b)(1)(C) of title XXI, a child with coverage under a group health plan or group health insurance coverage that is included under “excepted benefits” coverage may be provided with SCHIP funds, provided the child meets the other eligibility requirements of the separate program.

Policies that are limited to dental or vision benefits are among the “excepted benefits” identified in HIPAA. Therefore, a child with coverage under a limited-scope dental or vision plan would not be precluded from receiving coverage under a separate child health plan. Similarly, school health insurance policies with very restrictive coverage -- for example, coverage limited to treating an injury incurred in a school sports event -- would not preclude Title XXI eligibility, so long as they meet the definition of “excepted benefits” in HIPAA.

Comment: Two commenters requested that HCFA allow children to receive vision or dental services through a separate child health program when these services are not provided by the child’s current health plan.

Response: With respect to coverage of vision and dental

services, the statute does not permit States to provide coverage to children under separate child health programs when these children have other health insurance coverage, as defined by HIPAA even when coverage for certain services is limited. States that are concerned about ensuring that children receive such services may wish to consider expanding eligibility under Medicaid, which does not exclude children with other health insurance coverage from eligibility, or providing for such coverage with State-only funds.

Comment: One commenter noted that the exclusion of children of public employees places an additional administrative burden on States because they must verify whether the child has access to the State employee benefit system before a child may enroll in a separate child health program. Commenters also pointed out that under State welfare reform programs, many former welfare recipients are placed in entry-level State positions and State employee coverage is not necessarily affordable for them.

Response: We recognize that premiums and deductibles may present barriers to access to health coverage for children eligible for State health benefit coverage. However, the statute specifically prohibits coverage under a separate child health program of children who are eligible for health benefits coverage under a State health benefits plan. We have provided greater flexibility on this issue in the regulation, but we believe any

further flexibility would violate the statutory prohibition. The verification requirements are subject to State discretion and the State may accept the individual's statement about eligibility for health benefits coverage under a State health benefits plan. Therefore, we do not agree that verification requirements necessarily create an undue burden on States. In any event, we do not have the statutory authority to permit eligibility for children of public employees who have access to coverage under a State health benefits plan.

Comment: Many commenters requested that HCFA clarify the proposed nominal contribution of $10 for children of public employees by indicating whether this is an amount per child, per family, per month, or per year. Other commenters offered alternative suggestions for what could be considered "nominal," including: allow flexibility among states; $15-$20; 5% or 10% of the family's income or a standard related to their ability to pay; 25-50% of the child's premium; 50% of the cost of the child's coverage; or 60% of the cost of family coverage (consistent with the standard set for employer-sponsored insurance). One commenter requested clarification on how a nominal State contribution of $10 could be verified.

Response: We agree that we were unclear in the proposed regulation regarding the definition of nominal contribution and have clarified in the final regulation that the $10 contribution

is per family, per month. While we appreciate the numerous suggestions submitted by commenters for alternative definitions of a “nominal” contribution, we did not change the $10 level in the final regulation. In selecting this level, we were attempting to offer States some flexibility in determining what constitutes eligibility for a State health benefits plan, within the limits on eligibility for a separate child health program imposed by the statute. In our opinion, the $10 nominal contribution achieves this balance. We have also added to the regulation text the “maintenance of effort” provision discussed in the preamble to the proposed rule to indicate that if more than a nominal contribution was available on November 8, 1999, the child is considered eligible for a State health benefits plan. The contribution with respect to dependent coverage is calculated by deducting the amount the State or public agency contributes toward coverage for the employee only from the amount the State or public agency contributes toward coverage of the family.

For example, if a State contributes $100 per month to cover State workers themselves, but contributes $150 per month to cover the cost of the State workers themselves and their dependents, then the contribution toward dependent coverage would be $50 and would clearly exceed the $10 nominal contribution amount. A more complicated scenario that has arisen with certain States occurs

when States offer flexible spending accounts in which employees are given a defined contribution amount and can choose from an array of health insurance options. Under these flexible spending plans, the State employees usually choose from plans that have a range of costs, some of which cost less than the State contribution, and some of which cost more than the State contribution. In such cases, if the State contributes $100 toward the cost of insuring the State workers themselves, and there are insurance options available that only cost $85 per month, then the extra $15 dollars that the employees keep could be used to cover the cost of dependents and would be considered a contribution toward family coverage that exceeded the $10 minimum contribution amount. If the cheapest health insurance option under such a scenario were $95, then the contribution toward dependents would be $5 and would be below the $10 nominal amount.

We also have clarified the language in §457.310(c)(1)(i) to state that a targeted low-income child must not be eligible for coverage under a State health benefits plan on the basis of a family member's employment with a public agency even if the family declines to accept such coverage. We have clarified this language to reflect the clear intent of the statute that the child's eligibility for coverage is the determining factor in this case.

Comment: Several commenters requested clarification on the

adoption of the Medicaid definition of “inmate of a public institution.” Commenters noted that, to date, the Medicaid policy has been unclear with unresolved issues, and one commenter queried whether the discussion in the preamble of the proposed regulations makes the stated policy official for Medicaid. Two commenters supported the policy that a child is no longer considered an inmate if the child is discharged from a public institution for treatment in a hospital. One commenter also requested that the term “penal” be included in the preamble and the regulation, and that the definition explain that this refers only to children who are incarcerated after sentencing. One organization requested that the term “inmate of a public institution” not be used because it makes it problematic for ensuring that children in the juvenile justice system, who are not always serving time for a criminal offense but may be awaiting trial, receive adequate care. The organization believes that there is no rationale for making ineligible a child who is temporarily confined.

Response: We have not accepted the commenters’ suggestion to revise the definition of “inmate of a public institution.” This term is used in both title XIX and title XXI and is included in the Medicaid regulation at §435.1009. For purposes of consistency it is appropriate that the term be defined for separate child health programs in these regulations as it has

been defined in Medicaid.

Further, neither the statute nor the Medicaid definition differentiate between temporary confinement and incarceration after sentencing. However, as explained in the preamble to the NPRM, there is a distinction between the status of children under title XXI and under title XIX. Under title XXI, children who are "inmates of a public institution" are not eligible for a separate child health program. In contrast, under title XIX such children are eligible for Medicaid, but no FFP is provided for services provided while the child is in the institution. States may address the issue of temporary confinements by promptly enrolling or reenrolling children into the separate child health program when the child is discharged, as long as the child meets other eligibility requirements. We emphasize that the regulations in this subpart apply only to separate child health programs under title XXI. They do not establish Medicaid policy with respect to the definition of "inmate of a public institution."

Comment: We received many comments on the proposed policy related to a patient in an institution for mental diseases (IMD) and the requirement that a determination be made at the time of initial application or any redetermination. One State specifically supported this flexibility. Another pointed out that the proposed policy was inconsistent with the Medicaid policy and did not see why this situation was any different than

other changes in living arrangements. Another said that the proposal to deny eligibility conflicts with §457.402(a)(9) which includes IMD services in the definition of "child health assistance," and that denial of eligibility is not a reasonable compromise between these two provisions. This commenter recommended that States be allowed to decide which provision best fits their programs. One commented that this provision of the regulation should be withdrawn because HCFA has not finalized its guidance for Medicaid. Several organizations disagreed with the proposed policy based on the potential negative effect on the child. One of these commenters recommended that the child remain eligible for a separate child health program until one year of creditable coverage has been secured for that child. One commented that it is unfair to cover some children and not others and that the policy on IMDs makes it very difficult to set accurate budget estimates and managed care rates. Another suggested that the exclusion apply only at the time of application so that the practitioner would not avoid referring a child for IMD services because the child might lose eligibility during his or her stay. This organization also said that this would allow consistent continued eligibility during an IMD stay for children who have been determined eligible for an SCHIP Medicaid expansion or separate child health program. Several commenters were concerned about continuity of care if the child

lost eligibility at redetermination and commented that the policy was in conflict with the policy to allow a spend down when the spend down was met by the family paying for the IMD. Several commenters expressed support for the policy in the proposed regulation. One noted that children are often in an IMD for a short period. One organization commented that separate child health programs should continue to cover IMD services unless the child is determined not to be eligible for the program.

Response: We have carefully considered the range of comments on this point and have adopted the policy set forth in the proposed rule as the final policy with respect to children who are patients in IMDs. As was described in the proposed rule, the IMD eligibility exclusion applies any time an eligibility determination is made, either at the time of application or during any periodic review of eligibility. We believe that this is the most reasonable interpretation of section 2110(b)(2)(A) of the Act, which excludes eligibility for residents in an IMD, in light of sections 2110(a)(10) and (18), which allow for coverage of inpatient mental health and substance abuse treatment services, including services furnished in a State-operated mental hospital. We also recognize that this policy may be perceived as treating children with similar needs inequitably based on the particular point in time at which their eligibility is being determined. However, we believe that this is the most reasonable

way to implement the two statutory requirements cited above.

We recognize the concern raised by some commenters that this policy differs from Medicaid rules on the IMD exclusion, and in response we note that the different treatment is due to differences between title XIX and title XXI; title XXI mandates an *eligibility exclusion* for residents in an IMD, while title XIX provides for a *restriction on payment* for services provided to IMD residents. We must also point out that in Medicaid expansion programs, Medicaid rules will continue to apply and IMD residents will be eligible for the Medicaid expansion program, but no Federal matching funds will be available for any services provided to the individual while residing in an IMD, unless the facility meets the requirements of subpart D of 42 CFR 441 to qualify as an inpatient psychiatric facility for individuals under the age of 21.

5. Other eligibility standards (§457.320).

Section 2102(b)(1)(B) of the Act sets forth the parameters for other eligibility standards a State may use under a separate child health program. With certain exceptions, the State may establish different standards for different groups of children. Such standards may include those related to geographic areas served by the plan, age, income and resources (including any standards relating to spend downs and disposition of resources), residency, disability status (so long as any standard relating to

disability does not restrict eligibility), access to other health coverage and duration of eligibility. We set forth these provisions at proposed §457.320(a).

In addition, under the statute, the State may not use eligibility standards that discriminate on the basis of diagnosis, cover children with higher family income without covering children with a lower family income within any defined group of covered targeted low-income children, or deny eligibility on the basis of a preexisting medical condition. We set forth these provisions at §457.320(b). We also proposed that States may not condition eligibility on any individual providing a social security number; exclude AI/AN children based on eligibility for, or access to, medical care funded by the Indian Health Service; exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified aliens (except that, in establishing eligibility for a separate child health program, we proposed that States must obtain proof of citizenship and verify qualified alien status in accordance with section 432 of PRWORA); or violate any other Federal laws pertaining to eligibility for a separate child health program.

In addition to the revisions made to this section based on the comments discussed below, we clarified the language in §457.320(b) to prohibit States from establishing eligibility

standards or *methodologies* which would result in any of the prohibitions listed. "Standards" traditionally have referred to the income eligibility level (for example, 133 percent of the Federal poverty level). "Methodologies" includes the deductions, exemptions and exclusions applied to a family's gross income to arrive at the income to be compared against the standard in determining eligibility. This is a technical change necessary to implement the intent of the statute that States not be permitted to cover children in families with a higher income without covering children in families with a lower income.

Comment: One commenter expressed concern that allowing eligibility standards related to geographic area, age, income, resources, and so forth will allow States to limit the scope of coverage to a smaller population, thereby defeating the goal of covering the maximum number of children. They recommend that HCFA ensure that States are maximizing, not minimizing, the number of children covered. Two commenters were specifically concerned that standards related to geography might encourage States to exclude hard-to-serve areas such as rural areas, although they recognized this provision was statutory.

Response: The flexibility afforded to States in establishing eligibility standards was granted by Congress under section 2102(b)(1)(A) of the Act. Although a primary purpose of SCHIP is to extend health insurance coverage to as many uninsured

children as possible, States are explicitly allowed by the law to adopt certain eligibility rules. We note that to date, States have generally designed and implemented broad coverage for children and we are hopeful that this will continue to be the case.

Comment: We received a few comments related to terminating benefits when a child reaches age 19. One commenter objected to terminating benefits when a child reached age 19, while another specifically supported doing so. A third commented that it would be clearer to say "not to exceed 19 years of age" than "not to exceed 18 years of age."

Response: Section 2110(c)(1) of the Act defines a "child" as an individual under 19 years of age. There is no statutory authority for payment to States for child health assistance provided to children who have reached age 19.

Comment: Several commenters expressed support for allowing States to define income and for allowing States flexibility in verifying income and establishing periods of review. One strongly supported allowing States to determine family composition as well as whose income will be counted and under what circumstances, because this approach could provide a basis for teens (without family support) to enroll themselves.

Response: We appreciate the support and agree that allowing States to define "family" and "income" might provide States the

flexibility to provide coverage to certain teens who are without family support.

Comment: One commenter requested that HCFA point out the advantage of using the same definition of income for separate child health programs and Medicaid.

Response: We urge States to use the same definition of income and the same methods of determining income for both separate child health programs and Medicaid. As discussed later in this preamble, using the same definitions and methodologies simplifies the screening process and helps ensure that children are enrolled in the correct program. HCFA can help States to identify ways to simplify Medicaid methodologies and to align the rules adopted for Medicaid and a separate child health program.

Comment: One commenter expressed concern that allowing States to use gross or net income as countable when determining whether the countable income is below the eligibility standard will result in State differences and families may be convinced to move to another State for coverage.

Response: Given the flexibility authorized by law, income tests would vary from State to State even if States were required to use the same method of arriving at countable income because the income standards to which the countable income is compared vary widely. Income standards (and often methodologies) for most Federally-assisted, means-tested programs vary from State to

State. Research in this area indicates that individuals move to be with family or for employment and generally do not move for the purpose of receiving means-tested benefits. Income standards vary widely in Medicaid and there has been no evidence that this has resulted in families moving from State to State.

Comment: Two commenters specifically supported eliminating pre-existing conditions as a reason for denial and stated that such a policy is important to children with special needs. Two additional commenters stated that if States may not deny eligibility based on preexisting conditions, it may conflict with contracts between a separate child health program and a health plan or with premium assistance programs.

Response: Section 2102(b)(1)(B)(ii) of the Act prohibits the denial of coverage based on preexisting conditions and §2103(f)(1)(A) prohibits eligibility restrictions based on a child's preexisting condition. We agree that this prohibition is very important in providing health care to low-income children with special needs and have included it at §457.320(b)(2) of the regulations. States that have contracts with health plans which restrict eligibility based on preexisting conditions will have to renegotiate the contracts or otherwise ensure that the affected children are provided with care that meet the standards of title XXI.

One limited exception to this rule is permitted. Under

§2103(f)(1)(B) of Title XXI, if a State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance, the plan may permit the imposition of those preexisting conditions which are permitted under HIPAA. This permits the imposition of preexisting conditions consistent with the requirements of such plans when the State is providing premium assistance through SCHIP to subsidize child or family coverage under a group health plan or group health insurance pursuant to §2105(c)(3) of the statute.

Comment: We received one comment specifically supporting State latitude to establish eligibility based on State-established disability criteria. Another commenter recommended that we add a new §457.320(b)(4) to specifically prohibit the use of eligibility standards that discriminate on the basis of diagnosis in accordance with section 2102(b)(1)(A).

Response: Section 2102(b)(1)(A) of the Act provides that an eligibility standard based on disability may not "restrict eligibility," although States may provide additional benefits to children with disabilities. This provision was included in the regulation at §457.320(b)(3). Section 2102(b)(1)(A) of the Act also provides that no eligibility standard may discriminate on the basis of diagnosis. We have revised the regulation at §457.320(b)(3), as suggested, to specifically prohibit

discrimination on the basis of diagnosis. Therefore, a State may establish eligibility standards that are based on or related to the loss of certain functional abilities, whether physical or mental, if those standards result in children with disabilities qualifying for coverage. A State cannot, however, establish eligibility standards based on or related to a specific disease.

Comment: We received a significant number of comments urging HCFA to add specific residency requirements. Many of the commenters were concerned about children of migrant workers and homeless children. One commenter specifically urged HCFA to require States to set forth rules and procedures for resolving residency disputes. One recommended that the regulations explicitly provide that families involved in work of a transient nature be allowed to choose to establish residency in the State where they work or in one particular State. One commenter recommended that States be required to expedite enrollment of migrant children. One recommended that States be prohibited from the following: denying eligibility to a child in an institution on the grounds that a child did not establish residency in the State before entering the institution; denying or terminating eligibility because of temporary absence; or denying eligibility because residence was not maintained permanently or at a fixed address.

Response: Because Congress has specifically allowed States

flexibility to establish standards, we do not establish general residency rules for States. However, we share the commenters' concern that certain children may be unable to establish eligibility in any State because of disputes over residency and do not believe that allowing such a result would be consistent with the overall intent of title XXI and the requirement that SCHIP be administered in an effective and efficient manner. We have revised paragraph (a)(7) and added a new paragraph (d) to §457.320 to specify residency rules in limited circumstances. In the case of migrant workers, when the child of a parent or caretaker who is involved in work of a transient nature, such that the child's physical location changes periodically from one State to another, the parent or caretaker may select either their home State or the State where they are currently working as the State of residence for the child. For example, if a migrant family moves temporarily from Florida to North Carolina and then returns to Florida during the course of a year as a result of the parents' transient employment, the parents can claim either Florida or North Carolina as the child's State of residence.

In other instances, where two or more States cannot resolve which is the State of residence, the State where a non-institutionalized child is physically located shall be deemed the State of residence. In cases of disputed residency involving an institutionalized child, the State of residence is the parent's

or caretaker's State of residence at the time of placement. We believe that a child who is placed in an out-of-State institution should remain the responsibility of the State of residence at the time of placement. Similarly, in cases of disputed residency involving a child who is in State custody, the State of residence is the State which has the legal custody of the child. As indicated in the preamble to the proposed rule, under *Shapiro v. Thompson* (394 US 618), a State cannot impose a durational residency requirement. We have also added this prohibition to §457.320(d).

We have not imposed further residency rules. However, we strongly recommend that States establish written inter-State agreements related to disputed residency. We note that the rules contained in §457.320(d)(2) of this regulation apply only if the States involved cannot come to agreement with respect to a child's residency.

Comment: We solicited comments on our proposal that the eligibility standard relating to duration of eligibility not allow States to impose a maximum length durational requirement or any similar requirement. We received three comments in response, and all three recommended that the regulations make it clear that States are prohibited from imposing time limits or lifetime caps on eligibility.

Response: Under section 2102(b)(1)(A) of the Act, States

have considerable flexibility in setting the standards used to determine the eligibility of targeted low-income children, including those related to duration of eligibility. This enables States to establish the period of time for which a child determined eligible for the State's separate child health program can remain covered prior to requiring a redetermination or renewal of eligibility. At the same time, it is important to ensure that States can identify children enrolled in a separate child health program who become ineligible due to a change in circumstances. Therefore, we have retained the provision in proposed §457.320(a)(10) and moved it to §457.320(e)(2) to require that States redetermine a child's eligibility at least every 12 months. Note that termination of a child's eligibility at the end of the specified period (e.g. after a redetermination review) would constitute a "denial of eligibility" subject to the requirements of §457.340(d) of this subpart and subpart K.

We agree that durational limits on eligibility are contrary to the intent of the program. We have added a new subsection §457.320(e)(1) to include a prohibition against imposing time limits, including lifetime caps, on a child's eligibility for coverage. That is, a State cannot deny eligibility to a child because he or she has previously received benefits. The prohibition against lifetime caps or other time limits on coverage is consistent with Congressional intent to provide

meaningful health care for children and will prevent unequal treatment of similarly-situated children simply because one child has been enrolled in the program longer than the other. It will also prevent the possibility of jeopardizing the health of low-income children by terminating or denying health care on the basis of circumstances unrelated to the child's needs. The prohibition against durational limits on eligibility does not prevent a State from limiting enrollment based on budget constraints, or capping overall program enrollment due to lack of funds. This is reflected in §§457.305(b) and 457.350(e). In addition, we have added a definition of "enrollment cap" in §457.10 of subpart A.

Comment: One commenter specifically supported the concept of 12 months of continuous eligibility. Another recommended that the regulations be more specific about the duration of eligibility. This commenter recommended an annual time period because health care should not be interrupted when income fluctuates, which the commenter believes happens frequently with the population being served. One commenter objected to requiring any interim screening process during an established 12-month continuous eligibility period.

Response: We see no basis to prohibit State review of eligibility on a less than annual basis. We do encourage States to establish an annual period of review and to adopt continuous

eligibility rules to avoid interruptions in a child's health care because of minor fluctuations in income. Frequent reviews can be a barrier to enrollment and redetermination and can reinforce the "welfare stigma." In addition, research shows that many children lose coverage at the time of redetermination.

Between the scheduled reviews, regular, periodic screenings are not required. A child always has the right to file for and become eligible for Medicaid if family income changes, and the State is required to take action on the application, even if the child is covered by a separate child health program. If a child enrolled in a separate child health program does not file an application for Medicaid, the State is not required to screen the child for Medicaid eligibility until the next scheduled redetermination, regardless of changes in the child's circumstances (other than reaching age 19).

Comment: We received a significant number of comments on the discussion about pregnant teens included in the preamble, many of which expressed support for our position.

One commenter suggested that Illinois KidCare is a good model under which a pregnant teen is automatically transferred to the Moms and Babies Medicaid Program. Another recommended that HCFA clearly state an expectation that States provide information to teenage enrollees on the possible benefits of seeking Medicaid if they are pregnant, rather than simply urging them to do so.

One commenter recommended that States be required to inform pregnant teens about the differences between their Medicaid and separate child health programs. This commenter also asserted that the benefits of keeping a trusted health care provider may override the benefits of broader coverage and lower out-of-pocket expenses and that States, therefore, should inform pregnant teenagers of the possibility that changing from one program to the other may require the teen also to change doctors. Two commenters recommended that it be made clear that States providing information about Medicaid and the opportunity to apply for Medicaid cannot be held responsible for any individual who does not complete the Medicaid application process.

Several commenters objected to the recommendation that pregnant teens switch to Medicaid midyear. They argued that this unnecessarily disrupts continuity of care and has negative effects on pregnant teens. One of these commenters recommended that pregnant adolescents in their second or third trimester and adolescents with high-risk pregnancies be allowed to continue to see their treating provider through pregnancy and the 60-day postpartum period. Another commenter stated that the regulation related to monitoring pregnant teens and moving them to Medicaid in the middle of an eligibility period goes beyond statutory authority.

One commenter contended that all benchmark programs require

pregnancy services and commented that establishing procedures for managed care contractors to notify the State of a teen's pregnancy would be cumbersome, expensive and a potential violation of the family's confidentiality.

Finally, one commenter was concerned that the discussion about pregnant teens not appear to foreclose separate child health programs from adopting pregnancy-related benefits for pregnant teens who are not eligible for Medicaid.

Response: We appreciate the comments, and we wish to clarify a number of points. In drawing attention to pregnant teens, it was not our intent to impose additional or unnecessary requirements on States nor to promote procedures that would disrupt the medical care of pregnant teens. Our intent was to ensure that pregnant teens are provided with sufficient, clear information about Medicaid to make an informed choice about staying in the separate child health program or applying for Medicaid. States are not required to monitor teens for pregnancy and cannot be held responsible for teens who choose not to apply for Medicaid. Managed care contractors in separate child health programs are not required to notify the State when a teen becomes pregnant. Finally, States may provide the same pregnancy-related services under separate child health programs that they do under Medicaid. We urge States to do this, but pregnancy-related services are not mandatory under separate child health

programs. We also urge States to make every effort to rely on the same plans and providers in their separate child health programs and Medicaid so that children who switch between programs because of changes in circumstances, including pregnancy, need not change providers.

While States are not under an obligation to ensure that teens enrolled in separate child health programs become enrolled in Medicaid if they become pregnant, we remind States that there are advantages to Medicaid for a pregnant teen even when the benefit package is the same. First, cost-sharing is prohibited for pregnancy-related services under Medicaid and premiums are prohibited if the woman's net family income is at or below 150 percent of the Federal poverty level. (Above that level premiums are limited to 10 percent of the amount by which the family income exceeds 150 percent of the Federal poverty level.) In addition, a child born to a woman who is eligible for and receiving Medicaid on the day the infant is born is deemed to have filed an application and been found eligible for Medicaid. That infant remains eligible for one year if residing with the mother, regardless of family circumstances. If the delivery is covered by a separate child health program because the mother does not apply for Medicaid, the infant might not be eligible for Medicaid instead of automatically eligible as would be the case had the delivery been covered by Medicaid.

Comment: Two commenters recommended that HCFA encourage States that have separate child health programs to provide newborn infants the same eligibility protections granted under Medicaid. Another recommended that HCFA allow pre-enrollment of newborns or automatic enrollment of newborns of pregnant teens enrolled in a separate child health program.

Response: The statute does not provide for automatic and continuous eligibility for infants under a separate child health program as it does under Medicaid. Moreover, it is also likely that due to higher income standards that most States apply in Medicaid, many infants born to teens enrolled in a separate child health program will be eligible for Medicaid and therefore not eligible for a separate child health program.

However, as discussed elsewhere in this preamble (in response to comments under both §§457.300 and 457.360), we have determined that States may use “presumptive eligibility” to enroll children in a separate child health program pending completion of the application process for Medicaid or the separate plan. We recognize the need of infants to have immediate coverage and consider the automatic enrollment of newborns born to mothers covered by a separate child health program at the time of the delivery into the separate program as an example of such presumptive eligibility. Presumptive eligibility is time-limited, however, and States choosing to

enroll these newborns must formally determine the infant's eligibility (including screening the infant for Medicaid eligibility) within the time frame set for completing the application process and determining eligibility.

As noted earlier, if the infant is ultimately found not to be eligible for Medicaid, costs of services provided during the period of presumptive eligibility may be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. Thus, States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

Alternatively, States can develop an administrative process to identify, prior to birth, an infant as a Medicaid-eligible individual as soon as he or she is born, as we understand some States have done. This would ensure that Medicaid coverage and services are immediately available to a Medicaid-eligible newborn child.

Comment: We received a large number of comments related to obtaining social security numbers (SSNs) during the application process. Many commenters specifically supported the prohibition against requiring the SSN in separate child health programs. Two

requested clarification as to whether an SSN can be required on a joint SCHIP/Medicaid application. A few recommended that SSNs be required for applicants as long as there is a Medicaid screen and enroll requirement. One commenter did not advocate asking for an SSN, but commented that the policy for separate child health programs and Medicaid should be consistent because families prefer to give all information at one time and having a distinction between the requirements for the two programs hinders States' efforts to create a seamless program.

Some commenters indicated that the prohibition against requiring SSNs for a separate child health program while requiring it for Medicaid will cause referral, tracking and coordination problems; handicap enrollment in States using a joint application; make it difficult to implement the screen and enroll provision; reinforce stereotypes; and prevent automatic income verification in States that have reduced the documentation requirements. Another added that this prohibition will impede efforts to identify children with access to State health benefits.

Finally, another commenter suggested that Medicaid medical support cooperation requirements include providing information about noncustodial parents and that this "section may be construed as excusing a Medicaid applicant from having to provide an SSN for all family members, including noncustodial parents

absent from the home."

Response: The requirements and prohibitions related to the use of a social security number are statutory. The Privacy Act makes it unlawful for States to deny benefits to an individual based upon that individual's failure to disclose his or her social security number, unless such disclosure is required by Federal law or was part of a Federal, State or local system of records in operation before January 1, 1975. Section 1137(a)(1) of the Social Security Act requires States to condition eligibility for specific benefit programs, including Medicaid, upon an applicant (and only the applicant) furnishing his or her SSN. Because SCHIP is not one of the programs identified in section 1137 of the Act, and Title XXI does not require applicants to disclose their SSNs, States are prohibited under the Privacy Act from requiring applicants to do so.

Thus, only the SSN of the individual who is applying for Medicaid (including a Medicaid expansion program under title XXI) can and must be required as a condition of eligibility. Children applying for coverage under a separate child health program cannot be required to provide a SSN, and States cannot require other individuals not applying for coverage, including a parent, to provide a SSN as a condition of the child's eligibility for either a Medicaid expansion program or separate child health program.

We recognize that these statutory provisions can be difficult to reconcile in practice. Under the law, a joint Medicaid/SCHIP application must indicate clearly that the SSN is only needed for Medicaid and not for coverage under a separate child health program, but a family often will not know if their child is or is not Medicaid-eligible. A State may request the SSN for all applicant children as long as the State makes it clear that family members are not required to provide the SSN and that the child's eligibility under the separate child health program will not be affected if the child's SSN is not provided. However, the State must also inform the family that Medicaid eligibility cannot be determined without the SSN and that the child cannot be enrolled in the separate child health program if the child otherwise meets the eligibility standards for Medicaid.

Comment: A significant number of commenters objected to the verification requirements pertaining to citizenship and alien status. Most of these commenters requested that subsection §457.320(c) be deleted. A number of the commenters pointed out that we proposed to require that States follow INS rules which were not yet mandatory. Additionally, they argued that the requirement in §457.320(b)(6) that States abide by all applicable Federal laws and regulations would be sufficient. Several commenters objected to the verification requirements for a number of reasons. A significant number of them commented that the

procedures are too burdensome. One commenter felt that proof of citizenship might discourage some citizens who do not have birth certificates from applying. Another commented that requiring proof and verification of alien status would delay access to care for alien children who are otherwise eligible.

Response: Section 432 of the PRWORA requires verification of citizenship for applicants of all "Federal public benefits" as defined in section 401 of the PRWORA. However, proposed regulations published by the Department of Justice, which is responsible for enforcing the verification provision, provide that a State may accept self-declaration of citizenship provided that (1) the federal agency administering the program has promulgated a regulation which permits States to accept self-declaration of citizenship and (2) the State implements fair and nondiscriminatory procedures for ensuring the integrity of the program at issue with respect to the citizenship requirement.

Requiring documented proof of citizenship can be a time-consuming and difficult process for many applicants, and therefore could create a significant barrier to enrollment. It also can create a significant administrative burden for the State. Therefore, consistent with the statutory intent to promote access to and enrollment in separate child health programs and HCFA's policy to provide States with flexibility to simplify their application processes and eliminate barriers to

enrollment wherever possible, we have modified §457.320(c). The regulation permits States to accept self-declaration of citizenship, provided that they have implemented effective, fair and nondiscriminatory procedures for ensuring the integrity of their application process with respect to self-declaration of citizenship.

For example, a State could implement a system to randomly check the documentation of some applicants and terminate the eligibility of any applicants found to have provided a false declaration. If the percentage of false declarations was found to be high, the State would need to take appropriate measures to remedy the problem -- including, if necessary, requiring documentation to verify the citizenship of every applicant.

Comment: One commenter asked for clarification of the difference between “proof” and “verification.”

Response: We have used “proof” to refer to documents provided by individuals. “Verification” is used to refer to the process of comparing the information in the “proof” to the INS records. An individual may be considered eligible based on “proof” while the information is being verified.

Comment: Several commenters urged that the regulations specifically prohibit requests for information about the citizenship or immigration status of non-applicants, including parents. One commenter indicated that States should be

prohibited from verifying the status of any non-applicant when the information is voluntarily provided.

Response: Information about the citizenship or alien status of a non-applicant cannot be required as a condition of eligibility. States may request this information if it reasonably relates to a State eligibility standard and it is made clear that the provision of this information is optional and that refusing to provide the information will not affect the eligibility of applicants. We strongly urge States not to request this information nor to verify it if voluntarily provided, as this has been found to be a strong deterrent to alien parents filing applications on behalf of their citizen children.

Comment: One commenter recommended that HCFA issue, through letter or manual and web site, Medicaid guidance on the categories of immigrants eligible for Medicaid and that these regulations reference that guidance.

Response: Section 3210 of the State Medicaid Manual, which is available through links set for in HCFA's web site at www.hcfa.gov, discusses immigrant eligibility for Medicaid following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, although it does not reflect changes to immigrant eligibility contained in the Balanced Budget Act of 1997. We also have posted a fact sheet on

the section of our web page addressing Medicaid and welfare reform. The fact sheet is entitled, “The Link between Medicaid Coverage and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996.” Guidance to State Medicaid Directors dated December 8, 1997 discusses changes in immigrant eligibility for Medicaid under the Balanced Budget Act of 1997. Finally, guidance dated January 14, 1998 discusses immigrant eligibility for benefits under title XXI. This guidance (in the form of “Dear State Medicaid Director or Dear State Health Official letters) can be found at “www.hcfa.gov.”

We will consider issuing more detailed instructions pertaining to the eligibility of immigrants for Medicaid and separate child health programs and posting such guidance on our web site.

6. Application and enrollment in a separate child health program (§457.340).

We proposed to require that the State afford every individual the opportunity to apply for child health assistance without delay. Section 2101(a) of the Act requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program. Because we have determined that proposed §457.361

"Application for and enrollment in SCHIP," is closely related to this section, in this final rule we have incorporated the provisions of proposed §457.361 into this section. We will respond to the comments concerning §457.340 of the proposed rule here, and to those concerning §457.361 of the proposed rule below, under §457.361.

Comment: We received a number of comments on this section. Many commenters were concerned about the complexity of the application process, particularly when States have a separate child health program. Several commenters recommended that HCFA require States to certify that they have conducted a review of their Medicaid and Title XXI application and redetermination procedures and have eliminated any unnecessary procedural barriers that discourage eligible children from enrolling in and retaining coverage. If differences remain, States should be required to identify in their State plan the reasons for the differences and explain how they are consistent with the coordination goals of title XXI. Other commenters added that families should not be forced to understand and navigate two sets of application, enrollment and redetermination procedures.

Several commenters focused on joint applications for Medicaid and separate child health programs. One commenter asked HCFA to highlight that States can use a joint application and a single agency. Another urged HCFA to require a joint application

process or, at a minimum, to conduct rigorous oversight of the screen and enroll procedures. A third specifically indicated that HCFA should require States to have a single form for children who are applying for both programs, that it be limited to four pages, that States be required to accept mail-in applications and that States notify families when their application has been received. Yet another stated that the burden should rest with the State that chooses not to have a joint application to establish that its application procedures are effective. This commenter also recommended that HCFA require that the same verification procedures be used for both programs and that families not have to take any additional steps in order for their application to be processed by Medicaid.

One commenter felt that the regulations should define a joint application *process* rather than referring to joint forms. This commenter believes that applicants should be subject to the same requirements and procedures -- including a single application, the same verification requirements, and common entry points -- for both programs, and that nothing additional should be required for children to enroll in Medicaid under one of the categories identified in §457.350(c)(2).

One commenter felt that States also should be required to certify that they have eliminated any unnecessary procedural barriers to children making a transition between regular Medicaid

and a Title XXI-funded program when they lose eligibility for one program and become eligible for the other. Another thought it would be useful for HCFA to mention that flexibility regarding the eligibility determination process is not limited to contractors. Provider employees or outstationed workers at provider locations are also capable of making these determinations under a separate child health program.

Two commenters emphasized the importance of States applying any simplifications adopted in the application process for Medicaid or a separate state program to children whose families also are on Food Stamps or TANF. Some States which generally allow families to apply for Medicaid on behalf of their children through a mail-in application reportedly do not accept mail-in applications from families who already happen to be receiving Food Stamps or TANF. In this commenter's view, such policies create inequities and impose unnecessary procedural barriers to Medicaid enrollment and HCFA should encourage States to review whether they have any such policies, and to eliminate them whenever possible.

Other commenters recommended that HCFA place emphasis not only on helping families to apply for coverage, but also on helping them to remain enrolled in coverage. They felt that the simplification strategies listed by HCFA should also include States' adopting the same redetermination period in Medicaid and

separate child health programs, and reducing verification requirements for redeterminations as well as for the initial application.

Response: States are required to establish a program that is "effective and efficient" and a process that allows every individual to apply for child health assistance without delay. Mail-in, joint program application forms, common entry points and applicable procedures, single agency oversight and administration, and simplified and consistent program rules and documentation requirements are several ways that States can facilitate families' ability to apply for the appropriate health coverage program as expeditiously as possible. These procedures can also simplify administration for States. While we are not requiring that States use any specific mechanism, States that do not take steps to streamline, align, and coordinate their enrollment process will have a more difficult time ensuring that children can apply for health insurance coverage without delay and that their application is assessed in an effective and efficient manner.

We encourage, but do not require, States to use a joint application for their separate child health program and Medicaid programs and to simplify the application as much as possible. We agree with the comment that States should construct a joint application process, rather than just a joint application.

States that have adopted the same or similar rules relating to application interviews, verification and managed care enrollment have an easier time coordinating the enrollment process. We note that most States with separate child health programs report they use a joint child health application and that joint applications do not necessarily need to cover all possible Medicaid eligibility groups.

Section 2102(c) requires coordination of the administration of SCHIP with other public and private health insurance programs, and we also will be monitoring States' coordination of enrollment in their separate child health program and Medicaid programs, including children's transitions from one program to the other. HCFA will pay particular attention to outcomes in States that lack many of the elements of a streamlined and coordinated system. When appropriate, such monitoring will include requests for States to identify the number of children found potentially eligible for Medicaid, the percentage of those children who have been determined eligible for and enrolled in Medicaid, and the percent determined eligible for and enrolled in the separate child health program. These data will help States and HCFA determine whether the State has developed an effective method to coordinate enrollment and ensure that children are enrolled in the appropriate program.

While States have and will continue to have the flexibility

to design their own unique application and enrollment systems, States will be held accountable to ensure that children are afforded the opportunity to apply for the appropriate program in a timely and efficient manner. We believe that most States have developed coordinated enrollment procedures and are continuing to improve their systems to promote enrollment of eligible children, and we will continue to work with the States in developing effective systems.

It is also true, as a few commenters pointed out, that eligibility determination for a separate child health program may be performed by a wide range of entities, as determined by the State. For example, State Medicaid agencies, health care plans and providers, and outstationed State or local eligibility workers also may determine eligibility.

Finally, we agree with the last two points made by the commenters. First, we agree that States' simplifying both initial application and redetermination processes is critical. Second, we also agree that States can reduce barriers to accessing health care for all families by applying any simplifications adopted in the application process for Medicaid and the separate child health program to the application process for children whose families also happen to be receiving, or applying for, Food Stamps or TANF benefits, and we encourage States to do so.

Comment: Several commenters requested that States be given flexibility to use the application for a program other than Medicaid or SCHIP.

Response: States may use a joint application with other programs. Proposed §457.340(b) was confusing and may have implied that States do not retain discretion over whether or not to combine the applications of different programs. Because we do not want to preclude States from including programs other than Medicaid and SCHIP in a joint application and because a regulation is not needed to allow States to adopt a joint application, we have eliminated §457.340(b). This in no way implies that States are prohibited from using joint applications. In fact, we continue to strongly encourage States to consider how joint applications might promote coverage of eligible children.

For example, the application for Medicaid and/or a separate child health program may be combined with an application for child care assistance or WIC. Joint applications can be an effective outreach and enrollment tool because they can help States reach families that are being served by other programs. States that use a joint application, however, must develop a process that allows every individual to apply for *child health assistance without delay*. If the application for the separate child health program and/or Medicaid is combined with an application for other services or benefits and sufficient

information is provided to make a determination of eligibility for child health coverage, that determination must not be held up because of information (or action) which is needed for the other program. Joint program applications, while an effective tool, must not result in delays that would be contrary to the intent of the statute and this section.

Comment: One organization commented that the regulations should clarify that underlying the provision at proposed §457.340(a) regarding the opportunity to apply without delay are title VI of the Civil Rights Act and the Americans with Disabilities Act.

Response: Underlying the provision that individuals be able to apply without delay is section 2101(a) of the Act, which requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program.

Of course, this opportunity must be available to all children, regardless of their race, sex, ethnicity, national origin or disability status. Thus, the civil rights laws must be adhered to in implementing this requirement, but are not the only statutory authority for this provision.

Comment: One commenter expressed strong support for the requirement that every individual be afforded the right to apply.

The commenter asserted that adolescents not living with their parents should be allowed to file their own applications and recommended that HCFA, through the preamble, encourage States to adopt policies that facilitate the filing of applications by adolescents themselves.

Response: As required by this section, States must afford every individual, including adolescents, the opportunity to apply for child health assistance without delay. We encourage States to consider how they might best ensure that adolescents, including those who are not living with their parents or caretakers, can apply for SCHIP. States can also allow adolescents to sign their own applications; but this is a matter of State law and we cannot require States to permit minors to do so.

Comment: One commenter stated that the regulations should address methods for allowing families to report changes in circumstances in an efficient, family-friendly manner, such as not requiring the family to complete a new application when circumstances change.

Response: Section 2101(a) of the Act requires that child health assistance be provided in an effective and efficient manner. A reporting system which requires that a child reapply every time there is a change in family circumstances affecting eligibility would not constitute effective and efficient

administration. The precise manner in which an individual reports changes is subject to State discretion, as is the form used for periodic redetermination. States should develop methods of reporting changes that pose as few barriers to uninterrupted eligibility as possible and do not require families to resubmit information that has not changed. States that have opted to provide continuous eligibility generally do not require reporting of any changes in circumstances except at regularly scheduled redeterminations.

7. Eligibility screening and facilitating Medicaid enrollment (§457.350).

Sections 2102(b)(3)(A) and (B) of the Act require that a State plan include a description of screening procedures used, at intake and at any redetermination, to ensure that only children who meet the definition of a targeted low-income child receive child health assistance under the plan, and that all children who are eligible for Medicaid are enrolled in that program. In accordance with the statutory provisions, we proposed at §457.350(a) that a State plan must include a description of these screening procedures.

More specifically, section 2110(b)(1)(C) of the Act provides that children who would be eligible, if they applied, for Medicaid are not eligible for coverage under a separate child health program. Section 2102(b)(3)(B) provides that States have

a responsibility to actually enroll children who have applied for a separate child health program in Medicaid if they are Medicaid-eligible.

As stated in previous guidance, referrals to Medicaid do not satisfy this “screen and enroll” requirement. In accordance with the statute, we proposed to require States to use screening procedures that identify any child who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(l) of the Act. However, since States are not mandated to cover children below the age of 19 who were born before October 1, 1983 under the poverty-level-related Medicaid groups, we also proposed at §457.350(c) to require, at a minimum, that a State use screening procedures that identify any child who is ineligible for Medicaid under the poverty level related groups solely because of age but is potentially eligible under the highest categorical income standard used under the State’s title XIX State plan for children under age 19 born before October 1, 1983. In almost all circumstances, we expected that the highest categorical income standard used for such older children will be the standard used for the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I) of the Act. These children are sometimes referred to as “Ribicoff children.” (See §435.222.) Mandatory coverage of the older children in poverty-level related

groups is being phased in and by October 1, 2002, all children under age 19 will be included in the poverty-level-related groups in all States.

In the preamble of the proposed rule, we encouraged States to identify any pregnant child who is eligible for Medicaid as a poverty-level pregnant woman described in section 1902(l)(1)(A) of the Act even though she is not eligible for Medicaid as a child. We noted that Medicaid coverage, cost-sharing rules and eligibility rules pertaining to infants may be more advantageous to a pregnant teen than coverage under a separate child health program.

We proposed at §457.350(d) that to identify children who are potentially eligible for Medicaid, States must either initially apply a gross income test and then use an adjusted income test for applicants whose State-defined income exceeds the initial test, or use only the adjusted income test for all applicants. We set forth the initial gross income test and the adjusted income test at proposed §457.350(d)(1) and (2) respectively.

As indicated in section 2102(b)(3)(B) of the Act, Congress intended that children eligible for Medicaid be enrolled in the Medicaid program. We proposed at §457.350(e)(1) that, for a child found potentially eligible for Medicaid, the State must not enroll the child in the separate child health program unless a Medicaid application for that child is completed and subsequently

denied.

At §457.350(e)(2) we proposed that the State must determine or redetermine the eligibility of such a child for the separate child health program if (1) an application for Medicaid has been completed and the child is found ineligible for Medicaid or (2) the child's circumstances change and another screen shows the child is ineligible for Medicaid. Finally, at §457.350(e)(3), we proposed that if a child is found through a State screening process to be potentially eligible for Medicaid but fails to complete the Medicaid application process for any reason, the child cannot be enrolled in a separate child health program. Enrollment in a separate child health program for such a child can occur only after the Medicaid agency determines that a child who has been screened and found likely to be eligible for Medicaid is not in fact eligible for Medicaid under other eligibility categories.

We also proposed to require at §457.350(f) (§457.350(g) in this final regulation) that States choosing not to screen for Medicaid eligibility under all possible groups provide certain written information to all families of children who, through the screening process, appear unlikely to be found eligible for Medicaid. We proposed that the following information must be provided to the person applying for the child: (1) a statement that, based on a limited review, the child does not appear to be

eligible for Medicaid but that a final determination of Medicaid eligibility can only be made based on a review of a full Medicaid application; (2) information about Medicaid benefits (if such information has not already been provided); and (3) information about how and where to apply for Medicaid.

We have incorporated the provisions of proposed §457.360, "Facilitating Medicaid enrollment," into §457.350 because the requirements of both sections relate to the steps which the State or contractor responsible for determining eligibility under a separate child health program must take to comply with the "screen and enroll" requirements of Title XXI. In §457.350(a), we therefore have added a requirement that the State plan include a description of the procedures the State will use to ensure that enrollment in Medicaid is facilitated for children screened potentially eligible for Medicaid and who are then determined by the State Medicaid agency to be eligible for Medicaid.

We will respond to the comments on the proposed §457.360 in our discussion of §457.360 rather than in our discussion of this section. Also, note that the obligations of the Medicaid agency in meeting the screen and enroll requirements are set forth in a new §431.636, which is discussed further in subpart M of this preamble, "Expanded coverage of children under Medicaid and Medicaid coordination."

We noted in the preamble that there is great concern among a

number of States and others that children will go without health care because of these screen and enroll policies. The concern centers around the perceived stigma of Medicaid. Some families may refuse to apply for Medicaid because they associate it with "welfare." Some families may not complete the Medicaid application process because it may be more complicated than the application process for a separate child health program, may require more documentation, or may otherwise be seen as more invasive into personal lives. We solicited comments on the extent of these problems and possible solutions. We received many comments concerning the screen and enroll requirements. These comments are addressed below.

Comment: One commenter indicated that the term "found eligible" should be used consistently. The regulations should not say that a child is "found eligible" for Medicaid through the screening process and then indicate that when the Medicaid application is processed the child is not "found eligible" for Medicaid.

Response: We agree with the comment. A child who has been found through the screening process to be potentially eligible for Medicaid has not been determined eligible for Medicaid. We have revised the regulations to use the terms consistently. As revised, the term "found eligible" is only used when a final action has been taken on a Medicaid application and the child has

been enrolled in Medicaid. The term “potentially eligible” is used when a screening indicates that a child appears to be eligible for Medicaid and therefore may not be enrolled in a separate child health program until action is taken on his or her Medicaid application.

Comment: One commenter suggested that the regulations require that States provide comprehensive training to eligibility determination workers (and other workers as appropriate) in both Medicaid and a separate child health program to ensure that all potentially eligible applicants are afforded the right to apply and that no eligible children are terminated inadvertently or inappropriately.

Response: One aspect of minimizing barriers and assuring appropriate action with respect to applications is providing adequate training to eligibility workers. States will need to ensure that such training has been, and continues to be, provided, as appropriate.

Comment: A significant number of commenters supported the policy that a child could be “found ineligible” for Medicaid through either a regular Medicaid application or through a screening rather than requiring that an actual Medicaid application be filed and a formal determination be made that the child is Medicaid-ineligible.

Response: The clear intent of title XXI is to provide

benefits only to children who do not meet Medicaid eligibility requirements in effect before title XXI was enacted. This policy ensures that SCHIP funds will be used to cover only newly eligible children and not supplant funds already available through Medicaid to cover eligible children at the applicable Medicaid FMAP. This policy also ensures that children who are eligible for Medicaid benefits and cost-sharing protections receive the benefits and protections to which they are entitled. At the same time, Congress intended for children to be able to apply for, and obtain, health care insurance as quickly as possible, without lengthy delay. Requiring a formal denial by the State Medicaid agency in all cases would not promote the intent of the law. Permitting children who are found unlikely to be eligible for Medicaid through a screening process to proceed with their application under a separate child health program without a formal Medicaid determination be made, best balances these two goals.

Comment: Some commenters were concerned that States would make the Medicaid application process difficult and unfriendly while making the application for a separate child health program simple so that families would choose to apply for the separate program but not Medicaid, and that the State would get the enhanced Federal match. One commenter particularly supported the policy that refusal to apply for Medicaid affects eligibility for

a separate child health program. A number of other commenters objected to the policy of denying eligibility for a separate program when a child is found potentially eligible for Medicaid but the family makes an informed choice not to apply for Medicaid or chooses not to complete the Medicaid application process. One commenter argued that this policy goes beyond statutory authority. Most of those objecting to the policy expressed concern that it would result in children going without health coverage at all.

Response: How well the screening process works depends in large part on State Medicaid application rules and procedures. States have broad discretion under federal law to simplify and streamline their enrollment processes. We encourage States to simplify the Medicaid application process and to make the division between separate child health programs and Medicaid appear seamless, and many States have done so.

While we recognize that some families may decide to go without insurance rather than apply for Medicaid, we believe that it would be contrary to the statutory purposes to permit States to enroll children in a separate child health program who have been found potentially eligible for Medicaid through a screening process. As many States have demonstrated, States have the flexibility to address most, if not all, of the reasons why families might prefer not to apply for Medicaid. If families are

reluctant to apply for Medicaid, the State may need to reexamine the Medicaid application and redetermination process, as well as its outreach and marketing strategies, to assess how barriers to participation can be eliminated. For example, States have shown that families are more likely to complete the Medicaid application process if face-to-face interviews are eliminated, resource tests for children are dropped and documentation requirements are reduced. If a joint application process and a single program name are used, the procedures can be made seamless and the difference between separate child health programs and Medicaid made almost invisible to the family. States are continuing to experiment with different ways to promote seamless enrollment and coverage systems.

HCFA will be focusing considerable attention over the coming months on ways to help States develop seamless, family-friendly application and eligibility determination systems and to promote best practices across States. These practices will not only help States meet the screen and enroll requirements, but also will help States identify and enroll the millions of uninsured children who are eligible for, but not enrolled in, Medicaid.

Comment: Many of those commenting on the screening requirements were concerned that not all children who are eligible for Medicaid will be identified. A number of commenters disagreed with the policy that the screening process only needs

to screen for eligibility under the children's poverty level groups described in 1902(l). Quite a few were concerned that children with special needs who might qualify for Medicaid under another eligibility group will end up enrolled in a separate child health program that may provide less coverage than Medicaid. Some urged HCFA to require that States ask whether a child is disabled or has special needs. Others disagreed with the statement in the preamble that requiring States to screen for eligibility under all possible groups would place an unreasonable administrative burden on States. These commenters pointed out that States have considerable flexibility to simplify eligibility under Medicaid, particularly under section 1931.

One commenter noted that screening and determining eligibility are not the same. This commenter suggested that it is quite feasible to devise a simple, short list of questions to screen for eligibility in non-poverty related groups, and that the regulations should require that States screen considering the most liberal income eligibility standard for the child given the child's age, disability and the family's prior eligibility for §1931. One commenter suggested that States be required to screen for eligibility for children under sections 1931 and 4913 of the Balanced Budget Act of 1997. Four others suggested that the regulations should require States to screen considering the highest effective income threshold, taking income disregards into

account.

One commenter expressed concern about the extent to which income exclusions and disregards must be applied in the screening process. This commenter suggested that the screening should include only the standard deductions applicable to all poverty-level Medicaid eligibility groups. Another commenter stated that requiring independent entities to be knowledgeable about income exclusions under other Federal statutes, particularly those which are not likely to be encountered, is contrary to simplification.

Finally, one commenter was concerned that a pregnant teen who could be eligible for Medicaid as a pregnant woman might be found ineligible for both a separate child health program and Medicaid if the screening process did not include a method of identifying pregnant teens.

Response: We have tried to balance the statutory screen and enroll requirements with the requirement that child health benefits be provided in an "effective and efficient manner," taking into consideration the fact that screening may be done by entities that may not be familiar with the intricacies of Medicaid eligibility. For this reason, we have not required a full Medicaid application or a formal decision on such an application before a child can be eligible for a separate child health program.

We have, however, reevaluated our position on screening for

eligibility under section 1931 of the Act in light of the fact that in some States the highest eligibility threshold for non-disabled children is applied through the §1931 eligibility group. We also recognize that some States expanded Medicaid eligibility through the authority of section 1115 of the Act, resulting in a higher eligibility threshold for some children. We have revised §457.350(b) (proposed §457.350(c)) to require that a State that has used the flexibility provided under §1931 to expand eligibility must screen for eligibility under one of the poverty level groups described in section 1902(l), section 1931 of the Act, or a Medicaid demonstration project under section 1115 of the Act, whichever standard generally results in a higher income eligibility level.

States that have expanded eligibility under section 1931 beyond the poverty level category generally have adopted similar income eligibility rules; at a minimum, the section 1931 income methodologies are not likely to be significantly more complicated than the poverty level rules. Further, States need not screen families under both section 1931 and section 1902(l). Rather, they must screen under whichever methodology generally results in a higher income eligibility level for the age group of the child applying for assistance.

Because we are requiring States to screen under whichever methodology *generally* results in a higher income eligibility

level, States do not have to apply every income and resource disregard used under its State plan. Disregards that apply only in very limited circumstances need not be routinely used in the screening process. For example, many families applying for coverage under section 1931 would be expected to have earned income, so earned-income disregards must be applied in the screening process. However, few applicant families would be expected to have income-producing property. Thus, a State that disregards such income under section 1931 would not have to apply this disregard in the screening process.

We had included proposed §457.350(c)(2) in the proposed rule to ensure that the children eligible for Medicaid under section 1902(a)(10)(A)(ii)(I) (the "Ribicoff children") would not be missed in the screening process. However, most of these children will be identified under the revised §457.350(b). Therefore, cognizant of the need to keep the screening process as simple as possible, we have removed proposed §457.350(c)(2) from the final regulation.

We share the commenters' concern about children with disabilities being left out of the screening process and strongly encourage States to screen for children who might be eligible for Medicaid on the basis of disability. Questions about a child's potential disability may be included on the separate child health or joint SCHIP/Medicaid application for follow-up. We require

States to ensure that parents are provided with information about all Medicaid eligibility categories and coverage, are encouraged to apply for Medicaid under other eligibility categories and are offered assistance in applying for Medicaid. However, we do not agree with the comment that a child should be denied coverage under a separate child health program unless a full Medicaid disability determination has been made. The definition of disability for Medicaid purposes is not easily understood by people unfamiliar with Medicaid eligibility rules, and screening for eligibility based on disability could be very time-consuming. We note that States have 90 days, rather than 45, to determine Medicaid eligibility when disability is involved. Moreover, particularly in light of recent State Medicaid expansions, most children who would be eligible for Medicaid on the basis of disability will also meet the eligibility requirements as a poverty level child.

We also do not specifically require States to screen for eligibility under section 4913 of the BBA. The State is responsible for ensuring that disabled children who lost SSI because of the change in the definition of childhood disability (“secton 4913 children”) are aware of their right to Medicaid benefits. States must identify and provide coverage for section 4913 children, but it is highly unlikely that a child who would be eligible as a section 4913 child would not be identified in

the screening process as potentially Medicaid eligible on the basis of his/her income alone. In any event, Medicaid confidentiality rules do not allow States to provide lists of section 4913 children to entities that determine eligibility for a separate child health program but that do not also determine Medicaid eligibility.

Comment: One commenter pointed out that a screening based on income alone would be insufficient in a State that continues to apply a resource test to children under Medicaid. They recommended that §457.350 be revised to clarify that, in such situations, States must evaluate whether children meet both income *and resource* tests for Medicaid eligibility.

Response: We agree that, in States that continue to apply a resource test to children under Medicaid, when an income screen indicates that a child is potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility under the applicable Medicaid resource test. A resource screen limits those cases in which a child is found potentially eligible for Medicaid based on an income test, but is then reviewed under Medicaid rules and found ineligible based on resources (and is then sent back to the separate child health program for another eligibility review). We have added a new paragraph (d) to §457.350 to include this requirement. If a State continues to apply a resource test for children under the eligibility groups

described in §457.350(b) (§457.350(c) in the proposed rule) and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing the family's countable resources to the appropriate Medicaid resource standard. In conducting the screening, the State must apply Medicaid policies related to resource requirements, including policies related to resource exclusions and disregards and policies related to resources for particular Medicaid eligibility groups. However, in an effort to balance the statutory mandate that children eligible for Medicaid not be enrolled in a separate child health program with the need to keep the screening process as simple as possible, States need not take into account disregards that apply only in very limited circumstances in the screening process. Any resource exclusions and disregards which the State does not plan to use in the screening process must be identified in the State plan.

Since most States no longer apply a resource test to children, this added screening requirement will not affect most States. State experience indicates that children who are income eligible seldom have resources in excess of the resource standard previously used, with the possible exception of a car that is usually needed for transportation to and from work. States have found that requiring information about resources that are highly unlikely to make a child ineligible, or that rarely provide a

family with a greater ability to purchase health coverage, is an unnecessary administrative burden, a barrier to eligibility, and helps to reinforce the "welfare stigma." HCFA encourages the few States with resource requirements for children to eliminate or otherwise simplify any remaining resource tests under both Medicaid and separate child health programs. However, any State that retains a resource test for Medicaid must screen all applicants who appear income-eligible for Medicaid for eligibility under the applicable resource test.

Comment: One commenter indicated that screening is particularly difficult when an employer-sponsored model is used for SCHIP. This commenter suggested that States be given the option to accept a lower Federal match, for example, the Medicaid match, in lieu of meeting the Medicaid screen and enroll requirements.

Response: We do not have the statutory authority to provide a lower match in lieu of meeting the Medicaid screen and enroll requirements. Furthermore, because eligibility determinations are distinct from determinations about the kind of coverage an eligible child will receive, there does not seem to be any reason why the screen and enroll requirements would present any particular problems for States with premium assistance programs. States are required to screen all children applying for coverage under a separate child health program.

Comment: We received a significant number of comments concerning the requirement that certain information about Medicaid be provided to families if a State uses a screening procedure other than a full determination of Medicaid eligibility. Many commented that this requirement is administratively burdensome, a waste of administrative resources, exceeds statutory authority, and is contrary to the purpose and goal of the separate child health program option provided by Congress. Some commenters believed that this requirement would mean that a full Medicaid determination needs to be made in every case. Others were concerned that it would be confusing to families whose children were found eligible for a separate child health program, would slow down the eligibility determination process, and would create a barrier to access in situations where the family did not want Medicaid. Several commenters stated that there is no evidence that Medicaid-eligible children are being missed in the screening process and that to the contrary, State-based evidence suggests that many more such children are being found than anticipated.

Other commenters did not think that the notice requirements went far enough and they urged HCFA to require that the information provided describe disability-based, medically-needy and §1925 transitional Medicaid eligibility. One commenter recommended that proposed §457.350(f)(1) be revised to read

"based on limited review, we could not tell if your child is eligible for Medicaid." Another recommended adding "and orally in a manner that is literacy and language appropriate" to the lead-in to the required list of notifications. One commenter recommended that the final rule include an example of notice language to be sent to children who are determined unlikely to be Medicaid-eligible as a result of a limited screening process. Several others questioned whether the cost of providing the information about Medicaid would be an SCHIP administrative cost subject to the 10 percent cap on administrative expenses.

Response: Providing information about Medicaid will not necessarily create a barrier to enrollment. Families are entitled to have complete information on which to base a decision about applying for coverage. We are pleased that reports from many States indicate that many Medicaid-eligible children are being found through the screening process. However, the results across all States are not uniform and there is no way to know how many other Medicaid-eligible children are not being identified. Because all families are entitled to have information on their child's eligibility for coverage, we are retaining this provision with clarification.

We agree that families need to understand that no formal determination of the child's Medicaid eligibility has been made, nor has the child been screened under all Medicaid eligibility

categories. We note that a Medicaid determination does not need to be made in every case, but rather only for those children screened as potentially eligible for Medicaid using the joint application, and that a Medicaid eligibility determination can only be issued by the State agency designated to make the determination. In the instance where the same agency that makes the Medicaid determination of eligibility also determines eligibility for the separate child health program, a determination of Medicaid eligibility must be issued, in addition to the notice required at §457.350(e).

We have clarified the language of proposed §457.350(f) at §457.350(g)(1) of this final rule to provide that the State must inform the family, in writing, that based on a limited review, the child does not appear to be eligible for Medicaid, but that Medicaid eligibility can only be determined from a full review of a Medicaid application under all Medicaid eligibility groups. We have not included actual or proposed notice language in the final rule. Due to the differences in Medicaid programs, the language necessarily will vary from State to State. However, we are working to identify good notice language and best practices and will disseminate this material to States.

We expect that the information will be comprehensive and include information about Medicaid eligibility based on disability, pregnancy, excessive medical expenses, or

unemployment of the family wage earner. We also expect that this information will be provided in a simple and straightforward manner that can be understood by the average applicant and that meets all applicable civil rights requirements, including the Americans with Disabilities Act (ADA). The information can be provided along with other information conveyed to SCHIP applicants or it can be a separate notice. The cost of providing information about Medicaid eligibility need not be a SCHIP administrative expense subject to the 10 percent cap. A State may choose to charge the cost of providing information about Medicaid as an administrative expense under title XIX.

Comment: A few commenters indicated that the regulations should make it clear that a child can be enrolled in a separate child health program while undertaking the full Medicaid application process. Other commenters recommended enrolling a child in a separate child health program for 45 days to allow processing of the Medicaid application.

Response: As discussed above, at its option, a State may provisionally enroll or retain current enrollment of a child who has been found potentially eligible for Medicaid in a separate child health program, for a limited period of time, as specified by the State, pending a final eligibility decision. However, the child cannot be “eligible” for the separate program unless a Medicaid application is completed and a determination made that

the child is not eligible for Medicaid.

As noted above, we have revised our policy based on the recent enactment of BIPA to permit health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and §435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with §435.1101 to no longer be constrained by the 10 percent cap.

Comment: We received several comments urging HCFA to emphasize opportunities for simplifying the screen and enroll process and making the process “family-friendly.” Among the suggestions were: using a joint application or a single State agency; avoiding confusing options for families to opt in or out of Medicaid; eliminating age-based rules; adopting the same verification requirements as Medicaid; adopting the same income and resource methodologies as Medicaid; eliminating documentation requirements in Medicaid that are not required by the separate child health program; and requiring that any simplifications in the application process that States adopt for Medicaid or a

separate child health program not be denied to children whose families also happen to be TANF or Food Stamp applicants or recipients.

Response: The suggested simplifications are ways in which confusing options and complex procedures can be eliminated and the screen and enroll process be made “family-friendly.” We encourage States to adopt these simplifications. As States experiment with new ways to coordinate their child health coverage programs, they are finding that alignment of program rules and procedures can greatly simplify the task of coordinating enrollment. As for children who are also applying for, or are receiving, Food Stamps or TANF, we emphasize that, while States may use joint child health, Medicaid, Food Stamp and TANF applications, they cannot condition Medicaid eligibility on Food Stamp or TANF requirements that do not apply to Medicaid. For example, if a State Medicaid program does not require a face-to-face interview to determine a child’s eligibility for Medicaid, a child applying for Medicaid and Food Stamps on a joint application cannot be denied Medicaid simply because the child’s family does not comply with the Food Stamp interview requirement. Similarly, States cannot condition eligibility for a separate child health program on Food Stamp or TANF requirements that do not apply to that program.

Comment: Many of those who commented on the screen and

enroll process were concerned generally about families “falling through the cracks” because of the back and forth between separate child health programs and Medicaid or going without any health care for a period of time because of the process requirements. One commenter was particularly concerned about children leaving State custody from foster care or the juvenile justice system, who are at great risk of failing to apply for health coverage after they leave State custody. A significant number suggested that the regulations provide that a State cannot require a child to reapply for a separate child health program if the child is screened potentially eligible for Medicaid, but later determined ineligible for Medicaid. Most suggested that the separate child health program application should be suspended or provisionally denied when a child is found to be potentially eligible for Medicaid, pending a final Medicaid eligibility determination.

Other commenters found the distinction between joint and separate applications confusing with respect to the screening requirements. The commenters requested clarification as to whether the procedures for use of joint applications also apply to separate child health programs.

Response: There are many policies and procedures that States with separate child health programs can adopt to ensure that children do not “fall through the cracks.” When a child is

identified through screening as potentially eligible for Medicaid, States may suspend, deny or provisionally deny the separate child health application. Alternatively, if the State has established a presumptive eligibility process for a separate child health program, the State may enroll an applicant in the separate child health program pending the formal determination of Medicaid eligibility; we have added a new section §457.355 to reflect this option. It should also be noted that we have revised our policy to allows health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

We also have clarified the regulations at §457.350(f)(5) (§457.350(e)(2) in the proposed regulations) to require that, if a child screened potentially eligible for Medicaid is ultimately determined not to be eligible for Medicaid, once the State agency or contractor that determines eligibility for the separate child health program has knowledge of the Medicaid determination, the

child's original application for the separate child health program must be reopened or reactivated and his/her eligibility under the separate child health program determined without a new application. We believe that most States currently follow this procedure to ensure that the screening process does not improperly deny coverage under the separate child health program.

As discussed below, we have also added a rule directed to the Medicaid agency that requires that agency to promptly inform the SCHIP agency or contractor when a child who has been screened as potentially eligible for Medicaid is found ineligible for Medicaid (see section 431.636 of this chapter).

We have clarified §457.350(f)(1) (§457.350(e)(1) in the proposed rules) to indicate that a State may *suspend, provisionally deny* or deny the application of a child screened potentially eligible for Medicaid. (Note that to provisionally deny an application is the same as finding the child provisionally ineligible for the separate child health program.) Putting the application into suspense for a reasonable period of time before taking action on it would preserve the child's initial application date and ensure follow-up on the part of the State agency or contractor after the specified time period had elapsed or the agency or contractor learned that the child has been determined ineligible for Medicaid, whichever is sooner. If a State provisionally denies the application and the child is

subsequently determined ineligible for Medicaid, the child's initial application would be reactivated as soon as the State agency or contractor that determines eligibility for the separate child health program learns of the denial of Medicaid eligibility. In either case, the family would not need to provide any additional information (unless there has been a change in circumstances that could affect eligibility).

In most circumstances, no further action on the part of the family will be necessary to reactivate or reopen the application for the separate child health program following a denial of Medicaid eligibility. For example, in States in which the State Medicaid agency also determines eligibility for the separate child health program, no further action on the part of the family will be required. Similarly, States that use a joint application and that closely coordinate the eligibility determination process (for example, through electronic transfers or by co-locating eligibility workers) can ensure that Medicaid determinations for children identified as potentially Medicaid-eligible can be made quickly and that the decision (and underlying information) can also be conveyed quickly back to the workers responsible for determining eligibility for the separate program.

We agree that the screening requirements are the same whether a joint application or separate applications are used, although the procedures States will need to adopt to meet these

requirements will vary depending on whether a joint application is used. Therefore, we have deleted proposed §457.350(b) to eliminate confusion. All States, including those that use a joint application, are required to meet the screening requirements in §457.350.

We have added a new subparagraph §457.350(f) to clarify the State's responsibilities for ensuring that the Medicaid application process for a child screened potentially eligible for Medicaid is initiated and, if eligible, that the child is enrolled in Medicaid, as required by section 2102(b)(3)(B) of the Act.

In general, in States that use a joint application, the State agency or contractor that conducts the screening shall promptly transmit the application and all relevant documentation to the appropriate Medicaid office or Medicaid staff to make the Medicaid eligibility determination, in accordance with the requirements of §431.636, a new provision which sets forth the Medicaid agency's responsibilities with respect to the screen and enroll requirements of title XXI. Because the agency administering the separate child health program may not be the agency authorized to make Medicaid determinations in the State, it is at the point when the joint application form is transmitted to the Medicaid office from the separate program that it becomes a Medicaid application. We have added the definition of "joint

application" at §457.301 to clarify this point and to facilitate the processing of joint applications. Specifically, we define a joint application as a form used to apply for a separate child health program that, when transmitted to the Medicaid agency following a screening that shows the child is potentially eligible for Medicaid, may also be used to apply for Medicaid. We encourage States that use a separate application for a separate child health program to design their applications so that families can easily waive confidentiality under SCHIP to allow the agency or contractor that conducts the screening to transfer information to the Medicaid agency when a child has been found potentially eligible for Medicaid.

In States which do not use a joint application for Medicaid and separate child health programs, the State agency or contractor that conducts the screening shall (1) inform the applicant that the child is potentially eligible for Medicaid; (2) provide the applicant with a Medicaid application and offer assistance in completing the application, including providing information about what, if any further information and/or documentation is needed to complete the Medicaid application process; and (3)promptly transmit the application and all other relevant information, including the results of the screening process, to the Medicaid agency for a final determination of Medicaid eligibility, in accordance with §431.636.

It should be noted that under most circumstances, the term "promptly" means that the entire process (including screening and facilitation between SCHIP and Medicaid) for determining eligibility should be completed within the 45 day period. However, we recognize that there are cases where the timing of the process is beyond the control of the separate child health program. For example, if the process for determining Medicaid eligibility after a screen reveals that the family's income has changed, making them eligible for the separate child health program, we understand that the need to transfer paperwork back and forth between programs can take additional time beyond the 45 days.

Alternatively, under §457.350(f), the State can establish other procedures to eliminate duplicative requests for information and documentation and ensure that the applications and all relevant documents of children screened potentially eligible for Medicaid are transmitted to the Medicaid agency or staff and that, if eligible, such children are enrolled in Medicaid in a timely manner.

We also have added a section §457.353(a) to require that States monitor and establish a mechanism to evaluate (1) the process established in accordance with §457.350 to ensure that children who are screened potentially eligible for Medicaid apply for and, if eligible, enroll in that program and (2) the process

established to ensure that the applications for a separate program of children who are screened potentially eligible, but ultimately determined by the Medicaid agency not to be eligible, for Medicaid are processed in accordance with §457.340 of this subpart.

Data collection will need to be a part of any mechanism developed to effectively evaluate the screen and enroll process. For example, States will need to collect data on the number and percent of children applying for a separate child health program who are screened potentially eligible for Medicaid; the number of those screened potentially eligible for Medicaid who ultimately are determined to be eligible versus the number determined not to be eligible for Medicaid; the number of those children ultimately determined not to be eligible for Medicaid whose applications for the separate child health program are processed; etc. These data will help States and HCFA evaluate whether the procedures States adopt are accomplishing the goal of enrolling children in the appropriate program or whether modifications are needed.

We have modified the language in §457.350(f)(5)(ii) to clarify that States must determine or redetermine the eligibility of a child initially screened eligible for Medicaid if the child’s circumstances change and under §457.350(e) another screening shows that the child *does not appear to be* eligible for Medicaid. We have added the phrase ”does not appear to be” to

reflect the fact that only the State Medicaid agency is authorized to actually determine that a child is ineligible for Medicaid. Contractors can only make a determination as to the *likelihood* of the child's eligibility for purposes of proceeding with the application for a separate child health program.

Second, we have added a new subparagraph at §457.350(f)(5)(iii) to clarify that, in determining or redetermining the eligibility for a separate child health program of a child screened potentially eligible, but ultimately determined not eligible, for Medicaid, the child may not be required to complete a new application, although it may supplement the information on the initial application to account for any changes in the child's circumstances or other factors that may affect eligibility.

We also have added a new subsection §457.350(h) to require that States which have instituted a waiting list for the separate child health program develop procedures to ensure that the screen and enroll procedures set forth in §457.350 have been complied with before a child is placed on the waiting list. This ensures that children who are eligible for Medicaid are not placed on a waiting list if a State has closed enrollment for its separate child health program. These requirements ensure that eligible children are enrolled in the appropriate program without delay and without unnecessary paperwork barriers. At the same time,

they give States ample leeway to design the system that works best for them. No one system is prescribed, but States will need to monitor and evaluate how well their system is working, and they will be held accountable for ensuring that the system they have designed and implemented complies with the statutory and regulatory requirements.

Comment: We received one comment that the regulations should clearly indicate that a State may cease accepting applications for its separate child health program when enrollment is closed.

Response: The State may stop accepting applications as one method of administering an enrollment cap. If the State is using a joint application, which is also an application for Medicaid, then the State must have provisions to assure that the Medicaid eligibility determination process is initiated, even if enrollment in the separate child health program has been suspended. If, after a State plan that does not authorize an enrollment cap is approved by HCFA, the State opts to restrict eligibility by discontinuing enrollment, the State must submit a State plan amendment in accordance with §§457.60 and 457.65 of this final rule.

Comment: Two commenters suggested that the preamble reiterate that a child who must meet a spend down does not have "other coverage" and may be eligible for the separate child

health program.

Response: We have not required States to screen for Medicaid eligibility under the medically needy groups described in section 1902(a)(10)(C) of the Act because of the uncertainty inherent in determining whether and when a spend down has been met. A child who is not yet "medically needy" because he or she has not yet met the spend down requirements is not considered to be eligible for Medicaid for purposes of the screening requirement. However, an individual who could be eligible for Medicaid as medically needy with a spend down has a right to apply for Medicaid, and should be informed of the spend down category. If a child is eligible without a spend down or if it is determined that the spend down has been met, then the child would be eligible for Medicaid and would not be eligible for the separate child health program. Information about the State's medically needy program must be included in the information provided to applicants for a separate child health program.

Comment: In response to our request for comments on the extent of the Medicaid "stigma" problem and possible solutions, several commenters noted that poor coordination between separate child health programs and Medicaid expansions contributes to the stigmatization of Medicaid. One commenter noted that many working people take pride in their achievements and posited that they prefer to pay their own way rather than participate in what

they perceive as a public assistance program. This commenter felt that people's desire for self-reliance is not an attitude that public policy can (or should) change.

According to the commenters, a program is more likely to be successful in insuring children if these attitudes are taken into account. Two commenters said that negative reactions to Medicaid are due to its historic association with welfare; discourteous or intrusive treatment by workers; difficult application processes; negative treatment by providers; negative personal experiences and those of friends and neighbors.

Several commenters suggested that the stigma can be alleviated by having a simple, joint enrollment process and creating a seamless environment. One commenter suggested that a non-public entity be allowed to enroll children in Medicaid. Another recommended that HCFA encourage States to offer applicants a choice of settings in which to be enrolled, because reliance on a public monopoly reinforces the stigma. Additional suggestions included giving both programs one name; adopting a joint application; eliminating asset tests; encouraging presumptive eligibility; expanding outreach and enrollment sites; eliminating face-to-face requirements; and offering a single application site. One commenter also recommended that HCFA continue to research best practices and promote them.

One commenter suggested that ensuring that providers in both

programs are paid adequately and that provider networks in both programs provide convenient access to high quality services is a critical step as well. We received one suggestion that HCFA assess the barriers to Medicaid enrollment in each State and develop and implement a State-specific plan to address and remove such barriers. Several commenters asserted that the situation is difficult to resolve given the current statutory requirements and suggested that HCFA fund a study and make suggestions for legislative changes.

Response: We appreciate the responses on the stigma issue and have incorporated many of them in our guidance and suggestions to the States. We will continue to research and promote best practices and note that many States have successfully eliminated or greatly limited the welfare stigma which sometimes is associated with Medicaid and have converted Medicaid to a program that operates as, and is perceived to be, a health insurance program.

We encourage States to continue to simplify their processes and eliminate barriers to facilitate enrollment and retention among eligible individuals. We also encourage States to employ outreach efforts geared toward changing the perception that Medicaid is “welfare.” We urge States to make clear in all their informational materials about the TANF cash assistance program that coverage under Medicaid or a separate child health program

is not linked to TANF eligibility or enrollment and that, whether or not families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and any separate child health program.

8. Facilitating Medicaid enrollment(§457.360).

Under section 2102(b)(3)(B) of the Act, States are required to ensure that children found through the screening process described above to be eligible for Medicaid apply for and are actually enrolled in Medicaid. We proposed in §457.360(a) that the State plan must describe the reasonable procedures to be adopted to ensure that children found through the screening to be potentially eligible for Medicaid actually apply for and are enrolled in Medicaid, if eligible. Under proposed §457.360(b), States must establish a process to initiate the Medicaid enrollment process for potentially Medicaid eligible children and several options for States are provided.

We also proposed to require at §457.360(c) that a State ensure that families have an opportunity to make an informed decision about whether to complete the Medicaid application process by providing full and complete information, in writing, about (1) the State's Medicaid program, including the benefits covered and restrictions on cost-sharing; and (2) the effect on eligibility for coverage under the separate child health program of neither applying for Medicaid nor completing the Medicaid

application process.

Comment: We received one comment that States should not be required to "ensure" that children enroll in Medicaid because States cannot dictate to families, but can only assist them.

Response: The statute specifically requires that States "ensure" that children are enrolled. It is correct that a family cannot be forced to apply for Medicaid and that States cannot ultimately "ensure" that an eligible child is enrolled. However, it is the responsibility of the State to remove barriers to enrollment, adopt procedures that promote enrollment of eligible children, and ensure that the family understands the benefits of Medicaid and the consequences of not applying for Medicaid.

Comment: We received a number of comments pertaining to the information about Medicaid which must be provided to families. One commenter stated that it was not reasonable to expect States to "ensure" that a family's decision not to apply for Medicaid is an informed decision and that this could lead to costly litigation over whether the State has taken sufficient measures. A significant number of commenters were concerned that States would be required to provide "reams" of in-depth information about Medicaid and commented that general information ordinarily provided to any family interested in applying for Medicaid should be sufficient. Finally, one commenter recommended that information about the benefits of Medicaid be provided to

adolescents in a format and language that can be easily understood by the both the adolescent and the family.

Response: Sufficient information must be provided to families to enable them to make an informed decision about completing an application for Medicaid. We agree that information about Medicaid eligibility and the benefits of Medicaid should also be in a format that adolescents can understand as appropriate. We also note that the provision of information to families under proposed §457.360(c), section §457.350(g) of the final rule, only applies for States that use a separate application for their separate child health plan and those using a joint application which permits families to check a box on the application to elect *not* to apply for Medicaid.

In some cases, the general information provided ordinarily to any family interested in applying for Medicaid may provide sufficient information about Medicaid itself for these purposes. However, the State must also inform the family about the effect on eligibility for the separate child health program if the family chooses not to apply for Medicaid or not to complete the Medicaid application process, as many families will not realize that they do not have a choice between programs.

We have reconsidered the use of the term “ensure” because we agree that States cannot “ensure” that a decision is an informed one, no matter how much or how understandable the available

information. States can only make the information available in an accessible way. We have revised the regulation at new §457.350(g) (proposed §457.360(c)) to require that States provide sufficient information to enable the family to make an informed decision.

Comment: One commenter suggested that, because Medicaid eligibility may result in automatic referral to CSE, States should inform families applying for the separate child health program about the rights and responsibilities associated with being found eligible for Medicaid, including the assignment of medical support rights and the right to claim an exemption from the cooperation requirements. The commenter is concerned that a mother applying for SCHIP, where there is no need for contact with the noncustodial parent, may not mention that she has been subject to domestic abuse at the time of applying, and might be automatically referred to CSE when there is good cause for not being referred.

Response: A Medicaid application for a child should not result in a referral to the CSE agency absent the cooperation of a parent. We agree that whenever a Medicaid or separate child health program application is filed, the family should be informed about the services offered by the CSE, its opportunity to take advantage of these services, and whether additional information will be required. Cooperation with establishing

paternity and pursuing medical support is not a condition of a child's eligibility for Medicaid. Parents can be asked whether they would like to pursue medical support through CSE, but a cooperation in obtaining CSE cannot be required as a condition of a child's eligibility for Medicaid. If a parent also is applying for Medicaid, the parent should be informed of the acceptable reasons for refusing to cooperate and of the distinct consequences for the parent's and child's eligibility of not cooperating if none of the acceptable reasons applies.

Comment: One commenter noted that States should be given flexibility in the areas of application and enrollment. Another commented that the proposed regulations are overly prescriptive and exceed statutory authority by requiring States and SCHIP applicants to go through a tedious and administratively difficult process of obtaining a written waiver from applicants stating they do not wish to apply for Medicaid or complete a Medicaid application as required in proposed §457.360(c).

Response: As discussed in the responses to several comments below, States have a great deal of flexibility in the areas of application and enrollment. There is no requirement that SCHIP programs ask families for a waiver; in fact, under title XXI, States do not have the option of enrolling children in the separate program if a Medicaid screen indicated the child may be eligible for Medicaid, even if a family waived their right to

apply for Medicaid. States must inform families about the consequences for the child's coverage of not applying for Medicaid and develop systems to facilitate seamless enrollment in Medicaid for eligible children pursuant to §457.350. Under §457.350(f)(1), the State could suspend the child's application for the separate program unless or until a completed Medicaid application for that child is denied. This would preserve the child's initial application date and ensure follow-up on the part of the State SCHIP agency after the specified time period had elapsed.

Alternatively, a State may deny, or provisionally deny, the separate child health program application. As discussed earlier, if a State provisionally denies the application and the child is subsequently determined ineligible for Medicaid, the child's initial separate child health program application should be reactivated as soon as the SCHIP agency learns of the denial of Medicaid eligibility. The family would not need to provide any additional information (unless there has been a change in circumstances that could affect eligibility). If the child chooses not to apply for Medicaid, the denial or provisional denial under a separate child health program will stand (unless the child's circumstances change and a new screen shows that the child no longer appears potentially eligible for Medicaid).

Comment: Several commenters were concerned that the

application process for Medicaid would be a barrier to enrollment in a separate child health program. Some expressed concern that the proposed rule would fail to prevent States from using unnecessary administrative barriers and hostile or adversarial treatment by Medicaid eligibility workers as a means of discouraging families from successfully completing a Medicaid application and one urged HCFA to prevent States from requiring that applicants screened potentially Medicaid-eligible go through complicated, time-consuming and demeaning processes. Two recommended that HCFA prohibit States from making the process for applying for Medicaid more burdensome, onerous or time-consuming than the process for applying for a separate child health program. A few urged that the screen and enroll requirements be enforced, monitored, and evaluated to ensure that all children eligible for Medicaid are reached. One of the commenters urged HCFA to set high standards to ensure that States actually enroll screened children in Medicaid.

Response: Section 2102(b)(3)(B) of the Act requires States to describe in their State plan their procedures for ensuring that children screened potentially eligible for medical assistance under the State Medicaid plan under title XIX are enrolled in Medicaid. We have implemented that statutory provision at §457.350(a)(1). A simple referral to the Medicaid agency is not enough to meet this requirement. In §457.350, we

require that States take reasonable action to facilitate the Medicaid application process and to promote enrollment of eligible children into Medicaid.

We do not have the statutory authority to require any particular application process, or that the Medicaid application process be no more difficult than the application procedures for separate child health programs. However, we appreciate the commenters' concerns and encourage States to examine their administrative systems and to simplify and minimize barriers in their application and enrollment processes for both Medicaid and separate child health programs to the extent possible. We are pleased that most States are moving in this direction and will continue to provide technical assistance on this matter as needed.

Given Congressional concern that title XXI funds not be used to supplant existing health insurance coverage, ensuring compliance with the screen and enroll requirements of title XXI is a high priority for HCFA and will be strictly monitored, evaluated, and enforced. As previously discussed, we have added a new §457.353(a) to require States to monitor and establish a mechanism to evaluate the processes adopted by the State to implement the screen and enroll provisions of §457.350.

Comment: Two commenters recommended that States be required to send a notice after an initial screen finds potential Medicaid

eligibility.

Response: The State needs to provide written notice of any determination of eligibility under §457.340(d). If the State determines that an applicant is ineligible for coverage under its separate child health program, the State must provide written notice of that determination. In addition, under §457.350(g) the State must provide families with information to enable them to make an informed decision about applying for Medicaid; and under §457.350(f)(3), if a State does not use a joint application for Medicaid and its separate child health program, applicants that are screened potentially Medicaid-eligible must be given notice that they have been found potentially eligible for Medicaid, and be offered assistance in completing a Medicaid application (if necessary), and provided information about what is required to complete the Medicaid application process.

Comment: We received two comments related to the effective date of an application. One commenter requested that the regulations clarify that if a joint application is used, the date of the application for a separate child health program is also the date of application for Medicaid. One commenter believed that if an application for the separate child health program is denied, the State must provide notice to the applicant and must also continue to process the Medicaid application within the 45-day time frame.

Response: If a State uses a joint application for Medicaid and its separate child health program, the date of application for Medicaid may or may not be the same as the date of application for the separate program. As indicated earlier, this is because the State agency that determines eligibility for Medicaid may not be the same entity that determines eligibility for the separate program. In some cases, it may not be reasonable to hold the Medicaid agency responsible for determining eligibility within 45 days when it could not have initiated the determination process until the application was transmitted from the entity administering the separate child health program.

The SCHIP entity's responsibility in this case is to promptly transmit the application to the Medicaid agency immediately following the screen. Under most circumstances, the term "promptly" means that the entire process (including screening and facilitation between the separate child health program and Medicaid) should be completed within 45 days. However, we recognize that there are also circumstances where the timing of the process is beyond the control of the separate child health program and the separate child health program. For example, if the process for determining Medicaid eligibility after a screen reveals that the child's family income has changed, making them eligible for the separate child health

program, we understand that the transfer back and forth between programs can take additional time.

If a State uses separate applications for its separate child health program and Medicaid, States can but are not required to establish the date the separate application was filed as the effective date of filing for Medicaid. States have flexibility under the Medicaid program to establish the effective date of a Medicaid application. The regulations at §431.636 of this chapter do require that the SCHIP agency and the Medicaid agency coordinate to design and implement procedures that are developed to coordinate eligibility to ensure that eligible children are enrolled in the appropriate program in a timely manner.

Comment: Two commenters recommended that the regulations require that, even if a separate application is used for the separate child health program, the application form and any supporting verification must be transmitted to the appropriate Medicaid office for processing without further action by the applicant to initiate a Medicaid application. One commenter recommended that if an applicant is required to take any additional steps in order to apply for Medicaid, that the Medicaid agency inform the family of the steps it must take.

Response: As discussed above, under §457.350(f)(3), States that use a separate application must provide an applicant screened potentially eligible for Medicaid with a Medicaid

application; offer assistance in completing the application, including providing information about any additional information or documentation needed to complete the Medicaid application process; and send information and all relevant documentation obtained through the screening process to the appropriate Medicaid office or to Medicaid staff, to begin the Medicaid application process. An application for Medicaid would then be processed in accordance with Medicaid rules and regulations. Documentation (or photocopies) must be forwarded to the Medicaid agency along with other information wherever feasible. The family cannot be required to repeat information or provide documentation more than once. However, a separate child health application is not an application for Medicaid unless the State allows it to be used as such. Some States do use the separate child health program application as the Medicaid application when a child is screened as potentially eligible for Medicaid. This practice relieves the family and the State of the need to complete and review another application form.

As part of meeting their obligations under section 2102(b)(3)(B) of the Act, States must adopt reasonable procedures to ensure that a Medicaid application for children screened potentially eligible for Medicaid is completed and processed (provided that the family has not indicated that it does not wish to apply for Medicaid for the child). The obligations of the

Medicaid agency in meeting this requirement are set forth in §431.636 and discussed further in subpart M of this preamble, "Expanded coverage of children under Medicaid and Medicaid coordination."

Comment: A number of commenters suggested that the procedures in the regulations for facilitating Medicaid enrollment should specifically require that application assistance include bilingual workers, translators and language appropriate material or that the requirements of title VI and the ADA should be explained in the preamble. One commenter recommended that this include examples of how States and contracted entities can comply with these requirements.

Response: As required by §457.130, the State plan must include an assurance that the State will comply with all applicable civil rights requirements. In addition, §457.110 requires that States provide to potential applicants, applicants and enrollees information about the program that is linguistically appropriate and easily understood. Such materials and services, as well as compliance with the ADA, are required and important if States are to effectively reach and enroll all groups of eligible children. We elected not to explain in detail all applicable civil rights requirements identified under §457.130. However, interested parties can obtain additional information on these requirements by contacting the U.S. Health

and Human Services' Office for Civil Rights.

9. Application for and enrollment in a separate child health program §457.340 (proposed §457.361).

Because we believe that the provisions of this section are closely related to those contained in proposed 457.340, in this final rule, we have incorporated the provisions of these two sections in the final regulation at §457.340. However, we will respond to comments to proposed §457.361 here.

In this section, we proposed to require that States afford individuals a reasonable opportunity to complete the application process and offer assistance in understanding and completing applications and in obtaining any required documentation. Furthermore, we proposed to require that States inform applicants, in writing and orally if appropriate, about the eligibility requirements and their rights and responsibilities under the program.

We noted in the preamble to the proposed rule that, although not specifically addressed in statute, a State may choose to provide a period of presumptive eligibility during which services are provided, although actual eligibility has not been established.

We proposed that the State must send each applicant a written notice of the decision on the child health application and that the State agency must establish time standards, not to

exceed forty-five calendar days, for determining eligibility and inform the applicant of those standards. In applying the time standards, the State must count each calendar day from the day of application to the day the agency mails written notice of its decision to the applicant. We also proposed that the State agency must determine eligibility within the State-established standards except in unusual circumstances and that the State must specify in the State plan the method for determining the effective date of eligibility for a separate child health program.

In addition to the changes made in response to the comments discussed below, we have modified the language in §457.361(c) (§457.340(d) in this final regulation) to clarify that States must notify families whenever a decision affecting a child's eligibility is made -- whether the decision involves denial, termination or suspension of eligibility. In the case of a termination or suspension of eligibility, the State must provide sufficient notice, in accordance with §457.1180, to enable the child's parent or caretaker to take any appropriate actions that may be required to allow coverage of the child to continue without interruption. This clarification has been added in response to comments in order to ensure that children do not experience an unnecessary break in coverage because they have reached the end of an enrollment period.

Comment: Several commenters stated that HCFA should require States to notify the public of the priority standards, if any, for enrollment; inform individuals of their status on any waiting list; and maintain sufficient records to document that favoritism or discrimination does not occur in selecting individuals for enrollment.

Response: As discussed in the preamble to §457.305, above, if a State plans to institute a waiting list or otherwise limit enrollment, it must include in its State plan a description of how the waiting list will be administered, including criteria for how priority on the list will be determined. In addition, §457.110 requires States to inform applicants about their status on a waiting list.

Comment: We received several comments on the proposed requirement that a State determine eligibility under a separate child health program within 45 days. One commenter stated that the date of the application should not be the beginning of the 45 day period but rather the date that the application is received in the separate child health program eligibility office as there could be a delay for mailed-in applications. Another commented that the 45-day requirement does not take into account delays in obtaining necessary verifications from third parties such as employers or insurers. They suggested adding “or other party with information needed to verify the application [delays...]” or

just requiring States to determine eligibility in a timely manner. A third supported establishing a 45-day time limit and prohibiting the use of time standards as a waiting period, but recommended that the regulations provide more specificity regarding when notice of rights and responsibilities must be given and a notice of decision provided. Another commenter felt that the 45-day requirement should be removed, that mirroring Medicaid is burdensome and costly, and allowing mail-in and drop-off applications may mean it will take longer to reach people to get all the necessary information.

Response: We have not changed the requirement in §457.340(c) (proposed §457.361(d)) that States must determine eligibility for a separate child health program within 45 calendar days (or less if the State has established a shorter period) from the date the application is filed. We have, however, clarified §457.340(c)(2) (§457.361(d) in proposed rule) to require that States determine eligibility and issue a notice of decision promptly, but in any event not to exceed the time standards established by the State. This is consistent with the requirement that child health assistance be provided in an efficient manner, and that the 45-day period -- or other time period specified by the State -- may not be used as a waiting period. States have flexibility in deciding when an application is considered filed.

We agree that States should not be held responsible for delays caused by third parties beyond the State's control and have accommodated that concern in §457.340(c)(2). We also have revised §457.340(b) to specify that the notice of rights and responsibilities must be provided at the time of application. This ensures that families have the information they may need to proceed with the application process and successfully enroll their child.

Comment: We received two comments objecting to the requirement in §457.340(a) that States assist families in obtaining documentation. They commented that States are not in a position to do this and that the requirement has the potential for enormous administrative burden.

Response: We will not be removing the phrase from the regulation, but will offer clarification related to this provision as we think the commenter may have misinterpreted the proposed rule. We expect that, in offering application assistance, the State or contractor for the separate child health program will provide assistance to applicants in understanding what documentation is needed to complete their applications and, to the extent possible, will assist applicants in determining where they might obtain the needed information. For example, if the State's application process requires verification of income and the applicant does not understand how they can prove their

income, we would expect the State or the individual providing application assistance to be able to inform the family of the type of documentation (e.g., pay stubs or W-2 forms) needed and where the applicant might be able to obtain that information (e.g., from their employer). We do not expect a State to literally perform the task of obtaining the documentation for the applicant, unless it so chooses or the document is readily available to it, and agree with the commenters that such a requirement would be administratively burdensome. Most States have produced application materials and program brochures and operate telephone help lines that provide the type of assistance required by the regulation.

10. Eligibility and income verification (§457.360).

In this final regulation, we have moved two provisions of proposed §457.970, concerning eligibility and income verification, to new §457.360. In proposed §457.970, we proposed to require that States have in place procedures designed to ensure the integrity of the eligibility determination process, and to abide by verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations.

We proposed that States have flexibility to determine these documentation and verification requirements. In the preamble, we encouraged States to adopt procedures that ensure accountability

while permitting self-declaration to minimize barriers in the application and enrollment process.

We also noted at §457.970(c) that States with separate child health programs may choose to use the Medicaid income and eligibility verification system (IEVS) for income and resources, although they are not required to do so.

Finally, in §457.970(d) we proposed to allow States to terminate the eligibility of an enrollee for "good cause" (in addition to terminating eligibility because the enrollee no longer meets the eligibility requirements) -- e.g., providing false information affecting eligibility. Under the proposed regulations, the State would have to give such enrollees written notice setting forth the reasons for termination and providing a reasonable opportunity to appeal, consistent with the requirements of proposed §457.985.

Note that, in this final regulation, we have eliminated any specific reference to *income* verification systems, as income requirements are but one of a number of requirements for eligibility under a separate child health program.

Comment: One commenter expressed support for the flexibility HCFA gives States for verifying eligibility and income. Another recommended requiring that States' eligibility and income verification processes be designed to minimize barriers to and facilitate enrollment, and that the regulations

explicitly provide that States may use self-declaration of income and assets. A third suggested that HCFA should include a description of the opportunity that States have to use innovative quality control projects to ensure that allowing families to self-declare income does not increase the rate of erroneous enrollment.

Response: We appreciate the support for the flexibility afforded to States and encourage States to adopt eligibility and income verification procedures that do not create barriers to enrollment. At the same time, States must have effective methods to ensure that SCHIP funds are spent on coverage for eligible children. We note that States can use their discretion in establishing reasonable verification mechanisms and have included this in the regulation text at §457.360(b). We also encourage the creation of innovative projects to promote program integrity.

As stated in the preamble to the proposed rule, we also encourage States to develop eligibility verification systems using self-declaration or affirmation, and have decided to include this in the regulation text at §457.360(b), to eliminate any question about the rule. States may use the existing IEVS system to verify income, as long as the information was provided voluntarily. While States may ask for voluntary disclosure of Social Security numbers, disclosure of such information cannot be made a condition of eligibility. States may use existing IEVS

systems to verify income, as long as the information was provided voluntarily. We note that the integrity of a system which relies on self-declaration can be ensured through a variety of techniques. For example, a State could conduct a random post-eligibility check, requiring some applicants to provide documentation, or it could run computer matches of information provided by applicants against information available to the State through other sources.

Finally, we have deleted proposed §457.970(a)(2) (requiring compliance with the verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations) because it does not provide meaningful guidance to States on what they can and cannot do in designing their verification systems. If the system proposed violates other Federal laws or regulations, we will work with the State to bring its system into compliance.

Comment: One commenter noted his concern that the regulation authorizes States to terminate coverage of children for misconduct of a parent/caretaker and suggested that HCFA revise the definition of “good cause” to be more limiting. This commenter also noted his concern that the reference in proposed paragraph (d) to termination for good cause is troubling. The example of good cause as reporting false information on the application form does not seem to be good cause for a child

losing benefits if the false statement does not affect the child's eligibility. The commenter stated that this kind of standard is highly subjective and susceptible to abuse given the large amount of discretion States already have in administering their plans.

Response: We agree with the commenter's concern and have deleted the good cause provisions from the regulation text accordingly. Children should not lose eligibility, as long as they meet the eligibility standards under the approved State plan and consistent with title XXI requirements. Further discussion of these issues can be found in Subpart K.

11. Review of Adverse Decisions (§457.365).

Finally, we proposed in the NPRM to require that States provide enrollees in separate child health programs with an opportunity to file grievances and appeals for denial, suspension, or termination of eligibility in accordance with §457.985. In an effort to consolidate all provisions relating to review processes in new subpart K, we have removed proposed §457.365. Comments on proposed §457.365, are addressed in full in Subpart K -- Applicant and Enrollee Protections.